UPMC *for You*
Advantage (HMO SNP)
Affiliate of UPMC Health Plan

2012 **Individual Application**

HOW TO ENROLL IN UPMC *FOR YOU* ADVANTAGE:

APPLICATION INSTRUCTIONS: In order for your enrollment to be processed, please fill out each section completely. You must include all information and sign the application. If you would like help with your UPMC *for You* Advantage (HMO SNP) enrollment application, please call us at 1-866-405-8762, seven days a week, from 8:00 a.m. to 8:00 p.m. TTY/TDD users should call 1-866-407-8762.(*From February 15 through October 14, we are available from 8 a.m. to 8 p.m. Monday through Friday, and 8 a.m. to 3 p.m. on Saturday).

Important Reminder

Requirements for UPMC *for You* Advantage:
You must have Medicare Part A, Part B, and full Medical Assistance coverage at the time of enrollment.

NOTE: Medicare beneficiaries may enroll in UPMC *for You* Advantage through the CMS Online Enrollment Center located at www.medicare.gov. For more information, contact our plan at the phone number listed above.

Section 1 – Name and Address Information: Complete your name, address and contact information. The permanent address field must be your physical street address. Please do not list a P.O. Box address in the permanent address field.

Section 2 – Medicare Information: Provide your name, Medicare claim number, and effective dates (Parts A and B) exactly as they appear on your Medicare identification card. Your application cannot be made final until UPMC *for You* Advantage has your Medicare claim number and effective dates of coverage.

Section 3 – Primary Care Physician Selection: You will need to select a primary care physician (PCP) to coordinate your care. Please indicate the PCP name and 4-digit PCP number.

Section 4 – Other Health Insurance Information and Questions: If you have other health coverage or prescription drug coverage, please provide this information.

Section 5 – Other Questions: Provide answers to questions regarding end-stage renal disease and long-term care facility residence and if a UPMC Health Plan Representative assisted you in filling out the enrollment application.

Sign and Date the Application: After you have read the Rights and Responsibilities statements carefully and completed the enrollment application, please sign and date the application where indicated.

UPMC *for You* Advantage Rights and Responsibilities:

By completing this enrollment application I agree to the following statements:

(a) I understand that if I currently have health coverage from an employer or union, joining UPMC *for You* Advantage could affect my employer or union health benefits. I could lose my employer or union health coverage if I join UPMC *for You* Advantage. I read the communications my employer or union sends me. If I have questions, I will visit their website, or contact the office listed in their communications. If there is no information about whom to contact, my benefits administrator or the office that answers questions about my coverage can help.

(b) UPMC *for You* Advantage is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B coverage and full Medical Assistance.

(c) I understand that I can be a member of only one Medicare Advantage plan at a time, and that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan.

(d) I understand that it is my responsibility to inform UPMC *for You* Advantage of any prescription drug coverage that I have or may get in the future through another plan or program.

(e) I understand that it is my responsibility to tell UPMC *for You* Advantage before I move out of the service area. I understand that if I move permanently out of the service area, I need to notify the plan so I can disenroll and find a new plan in my new area.

(f) I understand that, as a member of UPMC *for You* Advantage, I have the right to appeal a plan decision about payment or services if I disagree. I will read the Evidence of Coverage document from UPMC *for You* Advantage when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

(g) I understand that, beginning on the date my UPMC *for You* Advantage coverage begins, I must get all of my health care services from UPMC *for You* Advantage network providers, except for emergency or out-of-area urgently needed services or out-of-area dialysis services. I understand that services authorized by UPMC *for You* Advantage and other services contained in my UPMC *for You* Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. I also understand that, without authorization, NEITHER MEDICARE NOR UPMC *for You* Advantage WILL PAY FOR THE SERVICES.

(h) I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with UPMC *for You* Advantage, he/she may be paid based on my enrollment in UPMC *for You* Advantage.

(i) I understand that a UPMC *for You* Advantage representative is required to call me within fifteen days of receiving this application to verify my enrollment in the plan. I will indicate which number UPMC *for You* Advantage should use at the time I sign and date this application.

White copy to: UPMC *for You* Advantage **Yellow copy to:** MEMBER

2012 INDIVIDUAL ENROLLMENT APPLICATION

UPMC *for You* *Advantage* (HMO SNP)
Affiliate of UPMC Health Plan

If you have questions about this form, please call us at 1-866-405-8762* seven days a week, from 8 a.m. to 8 p.m. TTY users should call 1-866-407-8762.

OFFICE USE ONLY		
Plan ID#:		Effective Date:
ICEP:	SEP(type)	AEP:
Not Eligible:		Prior Plan, if applicable:
Plan Representative:		
If you assisted with application, sign and date here:		
Application Mailed: ___________ Faxed: _____________		

1. TO ENROLL, PLEASE PROVIDE THE FOLLOWING INFORMATION		
Name: First M.I. Last		Telephone #: ( )
Date of birth: / /	Gender: ☐Male ☐Female	Alt. Telephone # *(optional)*: ( )
Social Security # *(optional)*:		
Permanent residence address (Street, apartment #): *P.O. Box is not allowed.*		
City: State: Zip Code:		County:
Mailing address (Street, Apartment #): Only complete if different from permanent residence address.		
City: State: Zip Code:		County:
Person to contact in emergency: *(optional)* Emergency phone #: Relationship to you:		
E-mail address *(optional)*:		
Do we have your permission to send you information (e.g. newsletters, health information) via e-mail? ☐Yes ☐No		
If you require information in an alternative format, please check one of the boxes below or contact UPMC *for You* Advantage Member Services at 1-800-606-8648*, seven days a week, from 8 a.m. to 8 p.m. TTY/TDD users should call 1-866-407-8762. ☐Large Print ☐Audio ☐Braille ☐Language, other than English Please list _________________		

White copy to: UPMC *for You* Advantage **Yellow copy to:** MEMBER

2. MEDICARE INFORMATION

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white, and blue Medicare card; or
- Attach a copy of your Medicare card or your letter from the Social Security or the Railroad Retirement Board.
- You must have Medicare Part A and Part B to join a Medicare Advantage Plan

We cannot consider your enrollment finished until you have given us this information.

MEDICARE HEALTH INSURANCE

Sample Only

Name of beneficiary: ______________________

Medicare claim number: ____________________

Is entitled to: Effective date:

☐ Hospital Insurance (Part A) _____________

☐ Medical Insurance (Part B) _____________

3. SELECT A PRIMARY CARE PHYSICIAN (PCP)

Name of selected PCP _________________________________ PCP # ____

Are you currently a patient of this physician?...☐Yes ☐No

4. OTHER HEALTH INSURANCE INFORMATION

1) Are you or your spouse working full-time?...☐Yes ☐No

Are you receiving group health insurance through your or your spouse's employer?...........................☐Yes ☐No

2) Will you have other medical coverage in addition to UPMC *for You* Advantage?...........................☐Yes ☐No

If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage: _______________________

Insurance company name:	ID number:
Insurance company phone number:	Group number:
Subscriber name:	Subscriber date of birth:

3) Do you receive Medical Assistance/ACCESS benefits?...☐Yes ☐No

If "Yes," please provide your Medical Assistance/ ACCESS #: _______________________

You must have full Medical Assistance coverage to be eligible for UPMC *for You* Advantage.

Some individuals may have other **drug coverage**, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs (e.g., PACE).

4) Will you have other prescription drug coverage in addition to UPMC *for You* Advantage? ....☐Yes ☐No

If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage: _______________________

Insurance company name:	ID number:
Other coverage phone number:	Group number:

5. PLEASE READ AND ANSWER THESE QUESTIONS

(a) Do you have End-Stage Renal Disease (ESRD)? (ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive.)..☐ Yes ☐ No

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

(b) Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If "yes," please provide your admission date: ____

Facility name: ______________________________Facility phone #: ___________________________

Facility address: ____

(c) Have you completed this application with assistance from a UPMC Health Plan representative?

☐Yes, face-to-face meeting ☐Yes, telephone call ☐No, completed by myself

White copy to: UPMC *for You* Advantage **Yellow copy to:** MEMBER

Release of Information: By joining this Medicare Advantage health plan, I acknowledge that UPMC *for You* Advantage will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that UPMC *for You* Advantage will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: (1) this person is authorized under state law to complete this enrollment; and (2) documentation of this authority is available upon request from Medicare. **Your signature on this application means that you have reviewed and understand the plan benefits and the Rights and Responsibilities listed at the BEGINNING of this form.**

Signature:____ Today's date:___________________

Verification call number:
Please call me to verify my enrollment at the telephone number I provided on the application or the number provided below:
☐ **Home number** ☐ **Alternate number** ☐ **Telephone number listed:** __________________________

If you are the **authorized representative**, you must sign above and provide the following information:

Name:____

Relationship to enrollee: ____

Address:____

Phone number: (______)____

Please return the WHITE COPY to UPMC *for You* Advantage in the postage-paid envelope provided. Please keep the YELLOW COPY for your records. Or you can fax the information to UPMC *for You* Advantage at 412-454-2973. Our mailing address is: UPMC *for You* Advantage, P.O. Box 2967, Pittsburgh, PA 15230.

White copy to: UPMC *for You* Advantage **Yellow copy to:** Member

UPMC HEALTH PLAN

One Chatham Center
112 Washington Place
Pittsburgh, PA 15219

www.upmchealthplan.com/snp

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