

HOW TO ENROLL IN UPMC *FOR LIFE* SPECIALTY PLAN:

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 Life* Specialty Plan (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 Life* Specialty Plan:

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 Life* Specialty Plan 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 Life* Specialty Plan 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: 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 Life* Specialty Plan 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 Life* Specialty Plan could affect my employer or union health benefits. I could lose my employer or union health coverage if I join UPMC *for Life* Specialty Plan. 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 Life* Specialty Plan 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 Life* Specialty Plan 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 Life* Specialty Plan 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 Life* Specialty Plan, 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 Life* Specialty Plan 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 Life* Specialty Plan coverage begins, I must get all of my health care services from UPMC *for Life* Specialty Plan 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 Life* Specialty Plan and other services contained in my UPMC *for Life* Specialty Plan 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 Life* Specialty Plan 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 Life* Specialty Plan, he/she may be paid based on my enrollment in UPMC *for Life* Specialty Plan.
- (i) I understand that a UPMC *for Life* Specialty Plan 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 Life* Specialty Plan should use at the time I sign and date this application.

2012 INDIVIDUAL ENROLLMENT APPLICATION

UPMC *for Life* Specialty Plan (HMO SNP)

UPMC Health Plan Medicare Program

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: <input type="checkbox"/> Male <input type="checkbox"/> Female		Alt. Telephone # (optional): ()
Social Security # (optional):			
Permanent address (Street, apartment #): <i>P.O. Box is not allowed.</i>			
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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If you require information in an alternative format, please check one of the boxes below or contact UPMC <i>for Life</i> Specialty Plan 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.			
<input type="checkbox"/> Large Print			
<input type="checkbox"/> Audio			
<input type="checkbox"/> Braille			
<input type="checkbox"/> Language, other than English			
Please list _____			

White copy to: UPMC *for Life* Specialty Plan

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 Life* Specialty Plan? 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 #: _____ 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 Life* Specialty Plan.

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 Life* Specialty Plan? 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: _____

If you answered "yes," you may not be eligible to enroll in UPMC *for Life* Specialty Plan if your admission in a long-term care facility meets Federal guidelines for institutional care.

(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

Release of Information: By joining this Medicare Advantage health plan, I acknowledge that UPMC *for Life* Specialty Plan 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 Life* Specialty Plan 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 Life* Specialty Plan in the postage-paid envelope provided. Please keep the YELLOW COPY for your records. Or you can fax the information to UPMC *for Life* Specialty Plan at 412-454-2973. Our mailing address is: UPMC *for Life* Specialty Plan, P.O. Box 2967, Pittsburgh, PA 15230.

UPMC HEALTH PLAN

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112 Washington Place
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www.upmchealthplan.com/snp

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