Individual Application

For assistance completing
this application, call
UPMC *for Life* Dual (HMO SNP)
toll-free **1-866-405-8762**
TTY/TDD users call
1-866-407-8762

UPMC *for Life*
UPMC Health Plan Medicare Program

H4279_16_3016 Accepted

UPMC *for Life*
UPMC Health Plan Medicare Program

Individual Enrollment Application

HOW TO ENROLL IN UPMC *FOR LIFE* DUAL:

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* Dual (HMO SNP) enrollment application, please call us at 1-866-405-8762, seven days a week, from 8 a.m. to 8 p.m. TTY/TDD users should call 1-866-407-8762. (From February 15 through September 30, 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* Dual:
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* Dual 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* Dual 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 in this section.

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.

White copy to: UPMC *for Life* Dual **Yellow copy to:** Member

UPMC *for Life* Dual 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* Dual could affect my employer or union health benefits. I could lose my employer or union health coverage if I join UPMC *for Life* Dual. I will 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 on whom to contact, my benefits administrator or the office that answers questions about my coverage can help.

(b) UPMC *for Life* Dual 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* Dual 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* Dual 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* Dual, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from UPMC *for Life* Dual 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* Dual coverage begins, I must get all of my health care services from UPMC *for Life* Dual 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* Dual and other services contained in my UPMC *for Life* Dual Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. If a service requires an authorization and one is not obtained, NEITHER MEDICARE NOR UPMC *for Life* Dual 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* Dual, he/she may be paid based on my enrollment in UPMC *for Life* Dual.

(i) I understand that UPMC *for Life* Dual and non-medical agencies providing Medical Assistance services may share information about my care or services I am receiving for better care coordination.

INDIVIDUAL ENROLLMENT APPLICATION

UPMC *for Life*

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/IEP:	SEP (type)	AEP:	OEPI:
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:
Email address *(optional)*:		
Do we have your permission to send you information (e.g., newsletters, health information) via email? ☐Yes ☐No		

If you require information in an alternative format, please check one of the boxes below or contact UPMC *for Life* Dual Member Services at the phone number above.

☐Large print ☐Braille

☐Audio ☐Language, other than English

Please list _____

My preferred date of enrollment is (enrollment date must be the first day of the month) _____.

White copy to: UPMC *for Life* Dual **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 _____

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* Dual? ☐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* Dual.

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* Dual? ☐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

Release of Information: By joining this Medicare Advantage health plan, I acknowledge that UPMC *for Life* Dual will release my information to Medicare and other plans, including state and federally funded service agencies, as is necessary for treatment, payment, and health care operations. I also acknowledge that UPMC *for Life* Dual will release my information, including my prescription drug event data to Medicare, which 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:_____

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

White copy to: UPMC *for Life* Dual **Yellow copy to:** Member

UPMC Health Plan

U.S. Steel Tower, 600 Grant Street
Pittsburgh, PA 15219

www.upmchealthplan.com/snp

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