Individual Application

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

UPMC *for Life*
UPMC Health Plan Medicare Program

H3907_16_3015 Approved

ENROLLMENT APPLICATION INSTRUCTIONS:

General Instructions: Please fill out each section of the enclosed application completely. **All information must be completed and the application signed in order for your enrollment form to be processed.**

Important Eligibility Requirements for UPMC *for Life* Options Applicants:

You must have Medicare Parts A and B coverage and reside in a nursing home or live in the community but require the same level of care as someone in a nursing home.

Section 1 – Acknowledgement of the Level of Care Assessment Requirement: Check the box if you agree to let us confirm your eligibility for the plan by verifying with the appropriate county department, for example, the Area Agency on Aging (AAA), or help schedule an assessment.

Section 2 – Name and Address Information: Complete your name and address information. The permanent residence address field must be your physical street address. Please do not list a PO box address in the permanent address field.

Section 3 – Medicare Information: Provide your name, Medicare Claim number, and effective dates (Parts A and B) exactly as they appear on your red, white, and blue Medicare identification card. You must have Medicare Part A and Part B to join a Medicare Advantage Plan. Your application cannot be finalized until UPMC *for Life* Options has your Medicare Claim number and effective dates of coverage.

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

Section 5 – Premium Payment Option: Select the method you would like to use to pay your premium, if applicable. If you select the electronic funds transfer (EFT) or credit card box on this application, you will receive a Payment Election Form with your UPMC *for Life* Options plan confirmation of enrollment letter. If you also have Medical Assistance, please disregard this section. If you have questions regarding the premium payments or to confirm if you have Medical Assistance, please call 1-866-405-8762.

Sections 6, 7, and 8 – Other Health Insurance Information and Questions: If you have other health or prescription drug coverage, please provide this information. Also provide answers to the questions in Section 8 regarding end-stage renal disease and long-term care facility residence.

Section 9 – Alternative Format Options: If you require information in an alternative format, please select the format that best fits your needs. If you do not see a format you need listed in this section, please contact UPMC *for Life* Options Member Services. If you do not need an alternative format, you may skip this section.

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

For translations or questions about this application, call UPMC *for Life* Options at 1-866-405-8762; TTY/TDD users should call 1-866-407-8762. Our hours of operation change twice a year. You can call us October 1 through February 14 from 8 a.m. to 8 p.m. seven days a week. From February 15 through September 30 you can call us from 8 a.m. to 8 p.m. Monday through Friday.

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

UPMC *for Life* Options 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 group or union, joining UPMC *for Life* Options could affect my current employer or union health benefits. I could lose my employer or union health coverage if I join UPMC *for Life* Options. 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, I will contact the benefits administrator.

(b) UPMC *for Life* Options 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. 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. **I understand that when I am enrolled in UPMC *for Life* Options, I will receive my Medicare prescription drug coverage through this plan. I do not need to enroll in a separate Prescription Drug Plan (PDP).**

(c) I understand it is my responsibility to inform UPMC *for Life* Options of any prescription drug coverage that I have or may get in the future through another plan. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

(d) UPMC *for Life* Options serves a specific service area. I understand that if I move permanently out of the service area that UPMC *for Life* Options serves, I need to notify the plan so I can disenroll and find a new plan in my new area.

(e) I understand that once I am a member of UPMC *for Life* Options, I have the right to appeal plan decisions about payments, services, or prescriptions if I disagree. I will read the Evidence of Coverage document from UPMC *for Life* Options when I receive it to know which rules I must follow to get coverage with this Medicare Advantage plan.

(f) I understand that beginning on the date UPMC *for Life* Options coverage begins, I must get all of my health care from UPMC *for Life* Options, except for emergency or urgently needed services or out-of-area dialysis services.

(g) Services authorized by UPMC *for Life* Options and other services contained in my UPMC *for Life* Options 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* Options WILL PAY FOR THE SERVICES.**

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

(i) If I have Medical Assistance benefits, I understand that UPMC *for Life* Options and nonmedical agencies providing Medical Assistance services may share information about your care or services you are receiving for better care coordination.

INDIVIDUAL ENROLLMENT APPLICATION

UPMC *for Life*

UPMC Health Plan Medicare Program

OFFICE USE ONLY				
Plan ID#:			Effective Date:	
ICEP/IEP:	OEPI:	AEP:	SEP (type):	Not Eligible:
Plan Representative/Broker:				
If you assisted with application, sign and date here:				
Application Mailed: _____ Faxed: _____				

If you have questions about this form, please call us at 1-866-405-8762. TTY/TDD users should call 1-866-407-8762.

Please contact UPMC for Life Options *if you need information in another language or format (e.g., Braille).*

1. ACKNOWLEDGEMENT OF THE LEVEL OF CARE ASSESSMENT REQUIREMENT

☐ By checking this box, I acknowledge that UPMC *for Life* Options will verify my eligibility for the plan and/or refer me to the appropriate county department to schedule an eligibility assessment before processing my application.

2. TO ENROLL IN UPMC *FOR LIFE* OPTIONS, PLEASE PROVIDE THE FOLLOWING INFORMATION

Name: First M.I. Last		Home phone number: ( )
Date of birth: MM/ DD/ YYYY / /	SEX: ☐Male ☐Female	Alternate phone number *(optional)*: ( )
Email address *(optional)*:		Do we have your permission to send you information (e.g., newsletters, health information) via email? ☐Yes ☐No
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:

3. PROVIDE YOUR MEDICARE INFORMATION

Please fill in the card to the right with the information from your red, white, and blue Medicare card. Otherwise, please attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. You must have Medicare Parts A and B to join our Plan. **We cannot consider your enrollment complete 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) _____

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

4. SELECT A PRIMARY CARE PHYSICIAN (PCP)

Name of selected PCP _____ PCP # _____

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

5. SELECT A UPMC *FOR LIFE* OPTIONS PREMIUM PAYMENT OPTION (if applicable)

☐ **Check this box if you have full Medical Assistance benefits. You ARE NOT responsible for paying the plan premium. You may go to Section 6.**

If you do not have full Medical Assistance benefits, please complete this section.

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by check, electronic funds transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

I would like to pay my monthly plan premium, if applicable, by:

☐ **Paper Check** ☐ **EFT** ☐ **Credit Card**

If you elected to pay your premium by credit card or EFT, you will receive a payment election form with your UPMC for Life Options plan confirmation of enrollment letter. You will need to complete and return this form with your banking or credit card information. Electronic payments cannot begin until we have received this completed and signed form.

☐ **Automatic deduction from my monthly Social Security or Railroad Retirement Board (RRB) benefit check**

The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

Late Enrollment Penalty: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we will include this amount on your monthly premium bill. If you are enrolled in a zero dollar premium plan and have a late enrollment penalty, we will send you a premium bill each month which you can pay by check, electronic funds transfer (EFT), or credit card. You can also choose to pay your late enrollment penalty by automatic deduction from your Social Security or RRB benefit check each month.

Part D IRMAA: If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium and/or late enrollment penalty. You can either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay **UPMC *for Life* Options the Part D-IRMAA.**

Low-Income Subsidy: People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of your plan premium, we will bill you for the amount that Medicare doesn't cover.

6. OTHER HEALTH INSURANCE INFORMATION

1) Do you or your spouse work 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* Options? ☐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) Are you enrolled in the Pennsylvania Medical Assistance program? ☐Yes ☐No

If "Yes," please provide your Medical Assistance number: _____

7. OTHER HEALTH INSURANCE INFORMATION (continued)

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* Options? ☐Yes ☐No

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

Insurance company name:	
ID number:	Group number:

8. PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

(a) Do you have end-stage renal disease (ESRD)? ☐ Yes ☐ No

You may be able to enroll in this plan if 1) you are currently enrolled in another UPMC Health Plan product OR 2) if you have had a successful kidney transplant and/or you no longer need regular dialysis. If "2" applies to you, please attach a note or records from your doctor. If this documentation is not attached, 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 the following information:

Name of facility: _____ Phone number of facility: _____

Address of facility: _____ Date admitted: _____

9. ALTERNATIVE FORMAT OPTIONS

If you require information in an alternative format, please check one of the boxes below or contact UPMC *for Life* Options at the phone number provided on page 1 of this application.

☐ Audio ☐ Large print ☐ Braille ☐ Language (please list) _____

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

Release of Information: By joining this Medicare Advantage health plan, I acknowledge that UPMC *for Life* Options 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* Options will release my information, including my prescription drug event data (if applicable), to Medicare, which may release it for research and other purposes that 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/premium and Rights and Responsibilities listed at the beginning of this form.**

I completed this application with assistance from a UPMC Health Plan representative.
☐ Face-to-face meeting ☐ Telephone call ☐ Completed by myself

My Preferred effective date of enrollment is (enrollment date must be the first day of the month):_____

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* Options in the **postage-paid envelope** provided. **Please keep the Duplicate Copy for your records.**

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

UPMC Health Plan

UPMC Health Plan

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

www.upmchealthplan.com/snp

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