# 2019 Providence Medicare Advantage Enrollment Packet

Thank you for your interest in applying for the Providence Medicare Advantage plan. Below are links to the items which are part of the Enrollment Packet you would receive if we were to mail it to you. Please take note and make sure to review the information. You will be receiving an "Enrollment Verification Call" from Providence within 7 days of the application receipt.

| Enrollment Packet – click links below to view the information |
|---|
| Star Rating<br>Download Application: Focus, Select & Extra / Harbor & Summit / Choice<br>Summary of Benefits: Choice Rx / Extra Rx / Focus / Harbor / Select / Summit<br>Pharmacy & Provider Search<br>Formulary |

| Initial Enrollment Period (IEP) |
|---|
| If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date. Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15th to December 7th. This will give you a January 1st effective date for your new plan. |
| **Annual Enrollment Period (AEP)** |
| Applications must be signed and dated on, or between October 15th and December 7th. *If they are signed prior to October 15th they will be returned to you with a new application.* If they are received after December 7th, you will not be able to change plans until the next AEP for January of the following year. |
| **Special Enrollment Period (SEP)** |
| There are a number of reasons for Special Enrollments; Loss of a job that provides benefits, death of a spouse who's plan provided benefits, moving to an area where your old plan is not available, etc… |

Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:

CDA Insurance LLC
PO Box 26540
Eugene, Oregon 97402

Fax: 1.541.284.2994 or 888.632.5470
Secure File Upload: Click here
Email: cs@cda-insurance.com

If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613. Our website: https://medicare-washington.com

Y0062_MULTIPLAN_CDA INSURANCE Washington 2019

**Office Use Only:**

**Name of staff member/agent/broker (if assisted in enrollment):**

_____ Date_____

Plan ID #:_____

Effective Date of Coverage:_____

ICEP/IEP:____ AEP:____ SEP (type):_____ Not Eligible:_____

PBP:_____

Tran. Code:_____

Plan #:_____

Premiums:_____

Group #:_____ Contract #:_____

PROVIDENCE
Medicare Advantage Plans
A division of Providence Health Assurance

P.O. Box 5548
Portland, OR 97228-5548

# Providence Medicare Advantage Plans
# Enrollment Request Form

Please contact Providence Medicare Advantage Plans if you need information in another language or format.

**Please choose which plan you want to enroll in:**

- ☐ Providence Medicare Focus Medical (HMO) $128
- ☐ Providence Medicare Select Medical (HMO-POS) $67
- ☐ Providence Medicare Extra + RX (HMO) $173

**Optional Supplemental Insurance**

- ☐ OR Basic Dental $33.70 premium will be added to your medical premium*
- ☐ OR Enhanced Dental $46.50 premium will be added to our medical premium*

**Please provide your information:**

☐ MR. ☐ MRS. ☐ MS. LAST NAME FIRST NAME M.I.

Date of Birth: ___/___/____ MM/DD/YYYY

Sex: ☐ Male ☐ Female

Phone Number: ( )

Email Address:

**Permanent Residence Street Address (P.O. Box is not allowed):**

City: County: State: Zip Code:

**Mailing Address** (ONLY if different from Permanent Residence Address):

City: County: State: Zip Code:

**Emergency Contact:**

**Phone Number:** **Relationship to you:**

**Please Provide Your Medical Insurance Information:**

Please take out your red, white and blue Medicare card to complete this section.

- Please fill out this information as it appears on your Medicare card.

-OR-

- Attach a copy of your Medicare Card or your letter from Social Security or Railroad Retirement Board

Name (as it appears on your Medicare Card)
_____

Medicare Number: _____

Is Entitled to: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Part A and B to join a Medicare Advantage plan.

**Attestation of eligibility for an enrollment period**

**Typically, you may enroll in a Medicare Advantage plan only during annual enrollment period from October 15th through December 7th of each year.** There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

**Please read the following statements carefully and check the box if the statement applies to you.** By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

**Do any of the following statements apply to you?** (Please check at least one)

- ☐ I am new to Medicare
- ☐ I am enrolling during The Annual Enrollment Period or Special Enrollment Period.
- ☐ I am leaving employer or union coverage on (insert date): _____
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date): _____
- ☐ I recently was released from incarceration. I was released on (insert date): _____
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date): _____
- ☐ I recently obtained lawful presense status in the United States. I got the status on (insert date): _____
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance or lost Medicaid) on (insert date): _____
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date): _____
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) *or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.*
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility.
  I moved/will move into the facility on (insert date): _____
  I moved/will move out of the facility on (insert date): _____
- ☐ I recently left a PACE program on (insert date): _____
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date): _____
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare or Medicare is ending its contract with my plan (insert date): _____
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date): _____
- ☐ I was enrolled in a Special Needs Plan (SNP), but have lost the special needs qualification required to be in that plan. I was disenrolled from my SNP on (insert date): _____
- ☐ I was impacted by a significant network change with a current plan and was notified on (insert date): _____
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the satements here applied to me, but I was unable to make the enrollment because of the natural disaster.
- ☐ Other qualifying event(s) please list: _____

If none of these statements applied to you or you're not sure, please contact Providence Medicare Advantage Plans at 1-800-603-2340 (TTY:711) to see if you are eligible to enroll. Our office hours are 8 a.m. to 8 p.m. (Pacific Time), seven days a week.

| **Important Questions** | |
|---|---|
| 1. Do you have End-Stage Renal Disease (ESRD)?<br>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. If we don't receive a note or records from your doctor we may need to contact you to obtain additional information. | ☐ Yes ☐ No |
| 2. Do you or your spouse work? | ☐ Yes ☐ No |
| 3. Will you have other coverage in addition to Providence Medicare Advantage Plans?<br>Some individuals may have other coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.<br>Please list your other coverage and your identification (ID) number for this coverage:<br>Name of other coverage: _____<br>ID # for this coverage: _____<br>Group # for this coverage: _____<br>Check all that apply: □ Medical □ Prescription □ Dental □ Vision | ☐ Yes ☐ No |
| 4. Are you a resident in a long-term care facility, such as a nursing home?<br>If "yes", please provide the following information:<br>Name of Institution: _____<br>Address of Institution: _____<br>City: _____ State: _____ Zip:_____<br>Phone Number of Institution:_____ | ☐ Yes ☐ No |
| 5. Are you enrolled in a State Medicaid program?<br>If yes, please provide Medicaid Number: _____ | ☐ Yes ☐ No |
| 6. Please choose the name of a Primary Care Provider (PCP): _____<br>Clinic name/PCP Location _____ | |
| Please contact Providence Medicare Advantage Plans at 1-800-603-2340 (TTY: 711) if you need information in an accessible format or language other than English. Our office hours are 8 a.m. to 8 p.m. (Pacific Time), seven days a week. | |

## Paying your plan premium

**You can pay your monthly premium, including any late enrollment penalty that you may currently have or may owe by mail or Electronic Funds Transfer (EFT) 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.**

If you don't select a payment option, you will get a bill each month.

**Please select a premium payment option**

☐ Receive a monthly bill
☐ Electronic Funds Transfer (EFT) from your bank. This will occur between the 15th and the 20th of each month and is the same date for all members. Please enclose a VOIDED check or provide the following:

**Account holder name:** _____

**Bank Routing Number:** __ __ __ __ __ __ __ __ __ __ __

**Bank Account Number** __ __ __ __ __ __ __ __ __ __ __ __ __

**Account type** ☐ Checking ☐ Savings

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check
I get monthly benefits from ☐ Social Security ☐ RRB

**(The Social Security/RRB deduction may take two or more months to begin after Social Security/RRB approve the deduction. You may receive an invoice for the first few months before the withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a letter and paper bills for your monthly premiums.)**

**If you are assessed a Part D-Income Related Monthly Adjustment Amount (D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for pay this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay Providence Medicare Advantage Plans the Part D-IRMAA.**

People with limited incomes may qualify for Extra Help to pay 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 co-insurance. 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 this premium, we will bill you for the amount that Medicare doesn't cover.

**PLEASE READ THIS IMPORTANT INFROMATION**

**If you currently have health coverage from an employer or union, joining Providence Medicare Advantage Plans could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Providence Medicare Advantage Plans.** Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefit administrator or the office that answers questions about coverage can help.

**Please Read and Sign Below**

**By completing this enrollment application, I agree to the following:**

Providence Medicare Advantage Plans is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or maybe get in the future. I understand that if I don't have Medicare prescription drug coverage, or a creditable prescription drug coverage plan (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. 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 15th-December 7th of every year), or under certain special circumstances.

Providence Medicare Advantage Plans serves a specific service area. If I move out of the area that Providence Medicare Advantage Plans servers, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Providence Medicare Advantage Plans, I have the right to appeal plan decisions about payment and service if I disagree.

I will read the Evidence of Coverage from Providence Medicare Advantage Plans when I get it to know which rules I must follow to get coverage with this Medicare Advantage Plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that selecting a Providence Medicare (HMO) plan means that on the date coverage begins; I must get all of my health care from Providence Medicare Advantage Network Providers, except for emergency or urgently needed services or out-of-area dialysis services. I understand that selecting a Providence Medicare (HMO-POS) plan means that with some exceptions, I may get non-urgent or non-emergent health care from providers outside the Providence Medicare Advantage Network at a higher cost-sharing should I choose.

Services authorized by Providence Medicare Advantage Plans and other services contained in my Providence Medicare Advantage Plans Evidence of Coverage document (also known as a member contact or subscriber agreement) will be covered provided plan rules are followed. If plan rules are not followed, **NEITHER MEDICARE NOR PROVIDENCE MEDICARE ADVANTAGE PLANS WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Providence Medicare Advantage Plans, he/she may be paid based on my enrollment in Providence Medicare Advantage Plans.

**Authorization and Declaration**

**Release of information:** By joining this Medicare health plan, I acknowledge that Providence Medicare Advantage Plans will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Providence Medicare Advantage Plans will release my information including my prescription drug event data if I am on a prescription drug plan 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. **Applicant sign below:**

**Signature:** _____ **Today's Date:** _____

**If the applicant is unable to sign the application and you are the authorized representative, please sign above and provide the requested information below:**

Name: _____

Address: _____

Relationship to enrollee: _____

Phone Number: (  )

*I understand enrollment in the plan listed above is optional. I also understand that I must maintain my coverage in Providence Medicare Advantage Plans in order to be enrolled in the optional plan selected. Additionally, I understand that I must pay the optional plan premium in order to maintain my coverage. I will read the optional benefit plan information when I receive it and learn my responsibilities as a member and what services are covered by the plan.

**AGENT USE ONLY:**

Agent Name: Tiffany Jackson Date: _____

ID #: 226783 Requested Date of Coverage: _____