MOLINA MEDICARE

Please contact Molina Medicare if you need information in another language or format (Braille).

Individual Enrollment Request Form
To Enroll in Molina Medicare, Please Provide the Following Information:

Please check which plan you want to enroll in from Molina Medicare (MM):

____MM Options (HMO) ____MM Options Plus (HMO) ____MM SmartSaver (HMO)
____ChoicePartners Medicare (HMO) ____Healthy Advantage (HMO)

State of Residence: ☐ CA ☐ FL ☐ MI ☐ NM ☐ OH ☐ TX ☐ UT ☐ WA

Last Name:	First Name:	Middle Initial	☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date: (__ __/__ __/__ __ __ __) (MM/DD/YYYY)	Sex: ☐M ☐F	Home Phone Number: ( )	Alternate Phone Number: ( )

Permanent Residence Street Address:

City:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address): ☐ (same as Permanent)

Street Address: City: State: ZIP Code:

E-mail Address: ____________________

Do you use the internet? ☐ Yes ☐ No **If "Yes", may we communicate with you via e-mail?** ☐ Yes ☐ No

Emergency contact: ____________________ **Phone Number:**____________________
Relationship to You: ____________________ **E-mail Address:** ____________________

Please Provide Your Medicare Insurance 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 Administration or the Railroad Retirement Board.

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

SAMPLE ONLY

Name: ____________________

Medicare Claim Number Sex ___

__ __ __ - __ __ - __ __ __ __ -___

Is Entitled To Effective Date

HOSPITAL (Part A) ____________________

MEDICAL (Part B) ____________________

Paying Your Plan Premium

If we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

You can pay your monthly premium by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

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 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/prescription help.

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. If you don't select a payment option, you will get a coupon book.

Please select a premium payment option:

☐ Get a bill coupon book

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: ______________________________

Bank routing number: ______________________ Bank account number: ______________________

Account type: ☐ Checking ☐ Saving

☐ Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please read and answer these important questions:

1. **Do you have End Stage Renal Disease (ESRD)?** ☐ Yes ☐ No

If you answered "yes" to this question and you don't need regular dialysis any more, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant.

2. **Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.**

Will you have other **prescription** drug coverage in addition to Molina Medicare? ☐Yes ☐No

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

Name of other coverage: ______________________ ID # for this coverage: ______________________ Group # for this coverage ______________________

3. **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 Institution: ______________________

Address & Phone Number of Institution (number and street):______________________

4. **Are you enrolled in your State Medicaid program?** ☐Yes ☐No

If yes, please provide your Medicaid number: ______________________

5. **Do you or your spouse work?** ☐Yes ☐No

Please choose the name of a Primary Care Physician (PCP) and/or Medical Group/IPA:

PCP:______________________________

Medical Group / IPA:______________________________

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format: _____ Spanish _____Other (Please specify) ______________________

(like Braille, audio tape, or large print)

Please contact Molina Medicare at (CA) 1-800-665-0898; (FL) 1-866-553-9494; (MI) 1-800-665-3072; (NM) 1-866-440-0127; (OH) 1-866-472-4584; (TX) 1-866-440-0012; (UT) 1-888-665-1328; (WA) 1-800-665-1029; TDD/TTY users please call 1-800-346-4128 if you need information in another format or language than what is listed above. Our office hours are Monday - Sunday, 8:00 AM to 8:00 PM, local time.

Please Read and Sign Below

By completing this enrollment application, I agree to the following: Molina Medicare 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 may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (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: November 15 – December 31 of every year), or under certain special circumstances.

Molina Medicare serves a specific service area. If I move out of the area that Molina Medicare serves, 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 Molina Medicare, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Molina Medicare when I get it to know which rules I must follow in order 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 beginning on the date Molina Medicare coverage begins, I must get all of my health care from Molina Medicare, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Molina Medicare and other services contained in my Molina Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MOLINA MEDICARE WILL PAY FOR THE SERVICES.**

Signature: (Do Not Print)___________________________________ **Today's Date:**___________

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

Name:____

Address:____

Phone Number: (____) ______-__________ **Relationship to Enrollee**___________________________

Office Use Only: Date of Receipt:_________________ Plan ID#:_______________ P# _________________

ICEP/IEP:_________ OEP:_________ AEP:_________ SEP (type):________ Not eligible:____________

Name of staff member/agent/broker (if assisted in enrollment):______________________________________
I confirmed with potential enrollee that a verification call will be conducted to ensure an understanding of the plan rules and enrollment verification process.

Phone #/Email address of staff member/agent/broker:____

Rep/Broker ID#: ______________________________ Effective Date of Coverage___________________

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Molina Medicare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Molina Medicare. 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 benefits administrator or the office that answers questions about your coverage can help.

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

Release of Information: By joining this Medicare health plan, I acknowledge that Molina Medicare will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Molina Medicare 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 of the individual 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 by Molina Medicare or by Medicare.