HEALTHSPRING

More from Medicare. More from life.

"HealthSpring, a Coordinated Care plan with a Medicare Advantage contract"
Y0036_HSNATMK1200 CMS Approved 08262010

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

To Enroll in HealthSpring, Please Provide the Following Information:

Please check which plan you want to enroll in:

Alabama
- HealthyAdvantage Plus (HMO) (PBP 001); $0/month
- HealthyAdvantage Premier (HMO-POS) (PBP 023); $35/month
- HealthyAdvantage Select (HMO) (PBP 010); $41/month
- HealthyAdvantage (HMO) (PBP 012); $0/month
- TotalCare (HMO SNP) (PBP 007); $0 - $23.60/month

Southern Mississippi
- HealthyAdvantage Plus (HMO) (PBP 002); $51/month
- HealthyAdvantage Premier (HMO-POS) (PBP 023); $88/month
- HealthyAdvantage (HMO) (PBP 011); $0/month
- TotalCare (HMO SNP) (PBP 004); $0 - $33/month

Northwest Florida
- HealthyAdvantage Plus (HMO) (PBP 005); $0/month
- HealthyAdvantage Premier (HMO-POS) (PBP 012); $35.50/month
- HealthyAdvantage (HMO) (PBP 004); $0/month
- TotalCare (HMO SNP) (PBP 010); $0 - $24.30/month

Alabama Medicare Retirees
- U.S. Steel (HMO) (PBP 804)

LAST Name:	FIRST Name:	Middle Initial	¢ Mr. ¢ Mrs. ¢ Ms.

Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ¢ M ¢ F	Home Phone Number: ( )	Alternate Phone Number: ( )

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

City:	State:	ZIP Code:

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

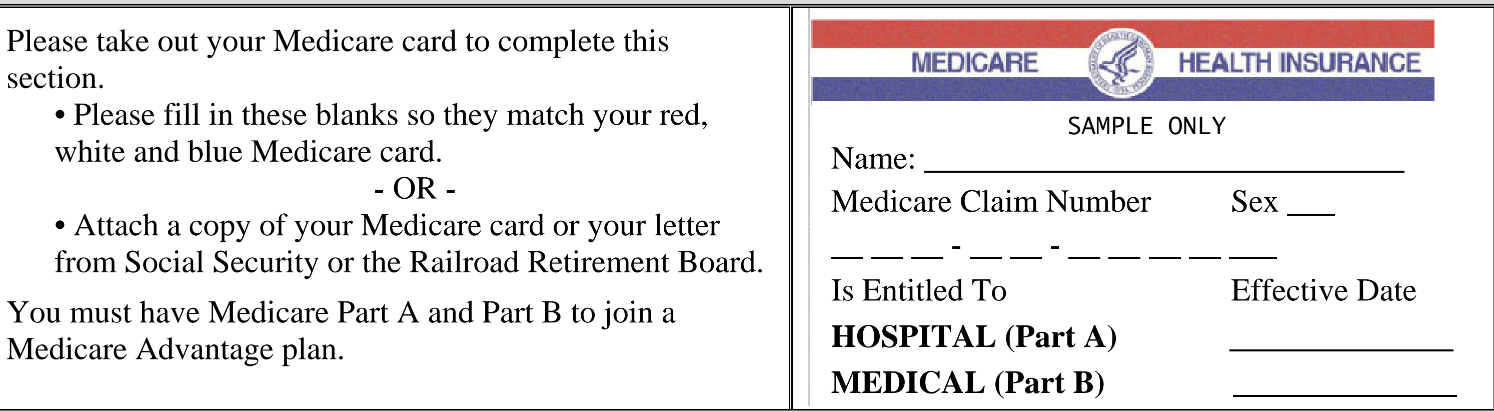
Street Address: City: State: ZIP Code:

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 Social Security or the Railroad Retirement Board.

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

MEDICARE HEALTH INSURANCE

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 (*or if you currently have a late enrollment penalty*), we need to know how you would prefer to pay it. You can pay your monthly plan premium *(including any late enrollment penalty that you currently have or may owe)* by mail, Electronic Funds Transfer (EFT) or 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% of 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.

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

Please select a premium payment option:

¢ Get a monthly bill by mail.

¢ 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 HealthSpring? ¢ 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), clinic or health center:

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:

Available languages: ¢ **Spanish** Available formats: ¢ **Large Print** ¢ **Braille**

Please contact HealthSpring at 1-888-767-1879 if you need information in another format or language than what is listed above. Our office hours are 7 days a week, 8:00am – 8:00pm CST. TTY users should call 1-877-262-9090.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining HealthSpring could affect your employer or union health benefits. You could lose your employer or union health coverage if you join HealthSpring. 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.

Please Read and Sign Below

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

HealthSpring 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: October 15 – December 7 of every year), or under certain special circumstances.

HealthSpring serves a specific service area. If I move out of the area that HealthSpring 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 HealthSpring, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from HealthSpring 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 beginning on the date HealthSpring coverage begins, I must get all of my health care from HealthSpring, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by HealthSpring and other services contained in my HealthSpring Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTHSPRING 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 HealthSpring, he/she may be paid based on my enrollment in HealthSpring.

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

Signature:	**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:
Name of staff member/agent/broker (if assisted in enrollment):______________________________
Plan ID #:______________________________
Effective Date of Coverage:______________________________
ICEP/IEP:_____ AEP:_____ SEP (Type):________________________ Not Eligible:________________________

Agent/Broker ID#:______________________ Agent/Broker **Signature**:______________________________
Date:______________________________
PCP #:____________________________ **County** in which Beneficiary Resides:____________________________

Continuity of Care Required:____

Source of Sale:
- ¢ Referral
- ¢ Lead; Code:______________________________
- ¢ Business Partner – BRK Code:______________
- ¢ Other:____________________________________

Orientation Date & Time:
____

Orientation Location:
____

Special Election (SEP) – PLEASE INDICATE TYPE:
- œ Qualify or Loss of Medicaid &/or LIS
- œ Moved to Service Area; Date: ____________________
- œ Loss of Employer/Retirement; Date: _______________
- œ Recently left a PACE program
- œ Move In or Out of SNF; Date: ___________________
- œ On Medicare Disability & Turning 65
- œ VA/TriCare – Drop PDP or MAPD For MA Only
- œ Other – Comments/Notes: ________________________
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Date Stamp Sales: Date Stamp Enrollment:

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