



Preferred Care Gold/GoldAnywhere Enrollment Application & Part D Application INDIVIDUAL

Terms of Participation

Please read these terms carefully. Your signature on this form indicates that you agree to all of the following:

I understand that the effective date of coverage is when I should begin using Gold or GoldAnywhere services. Preferred Care will send me final confirmation of my enrollment. I understand that I should not disenroll from any Medicare supplement or Medigap/Medicare select plan until I receive confirmation from Preferred Care.

By enrolling in Preferred Care Gold or GoldAnywhere, I authorize Preferred Care to use or disclose my personal health information for treatment, payment or health care operation purposes, as required by law. Those purposes include, but are not limited to, disease prevention and management, coordination of treatment and benefits, utilization and claims review, quality assessment and measurement, appeals and grievances, and accreditation, for the duration of this contract.

I understand that as a Gold or GoldAnywhere member, I have the right to ask about Preferred Care's decision about payment or services if I disagree.

I also understand that if I enroll in a stand-alone Prescription Drug Plan (PDP), I will automatically be disenrolled from Preferred Care Gold or GoldAnywhere and transferred to the Original Medicare Plan (fee-for-service program).

I understand that since I can be a member of only one Medicare Advantage plan at a time, I cannot enroll in more than one Medicare Advantage plan with the same effective date of coverage. If I do this, my enrollments will be canceled and I will have to fill out a new enrollment form to become a member of a Medicare Advantage plan.

I understand that if I choose to enroll in a different Medicare Advantage plan (whether or not it is sponsored by my employer), I will be automatically disenrolled from my previous plan.

I understand that it is my responsibility to inform Preferred Care before permanently moving or leaving the service area for more than 6 consecutive months. I also understand that if I am absent from the service area for more than 6 consecutive months, Medicare requires Preferred Care to disenroll me.

I understand that I may disenroll from this plan by sending a written request to the plan or by calling 1-800-MEDICARE (TTY: 1-877-486-2048). Until the effective date of disenrollment, I must continue to follow my health plan's guidelines. If I withdraw on any day of any month, my disenrollment will be effective the first day of the following month. Until the effective date of disenrollment, I must continue to follow my health plan's guidelines. There is an exception to this rule. Disenrollment requests received between November 15 and November 30 are usually effective December 1. However, since November 15 - December 31 is also the annual election period, I may ask for a January 1 disenrollment date.

I understand that if I disenroll from an employer-sponsored plan, I will be automatically transferred to the Original Medicare Plan (fee-for-service program).

STOP

PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining Preferred Care Gold or GoldAnywhere could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Preferred Care Gold or GoldAnywhere may change how your current coverage works. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Section 3: Medicare Card Information

Please fill in these blanks, so they look the same as what is on your red, white and blue Medicare card.

You must fill this out OR attach a copy of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board.

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

Medicare Health Insurance

Name _____

Medicare Claim # --

Is Entitled To: Hospital (Part A) ____ / ____ / ____

Medical (Part B) ____ / ____ / ____

Section 4: Primary Care Physician (PCP) - not required for GoldAnywhere

Primary Care Physician (*full name required*) Provider ID/Sequence # Address

OB/GYN: Provider ID/Sequence # Address

NOTE: Provider ID is found next to the name in the Gold Directory of Health Care Professionals.

Section 5: Please read and answer the following questions

1. Do you have End Stage Renal Disease (ESRD)?

Yes No

If you answered yes to this question and you no longer need regular dialysis or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not 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 EPIC.

Will you have other prescription drug coverage in addition to Preferred Care? Yes No

If yes, name of other coverage _____

ID # _____

Group _____

3. Are you a resident in an institution (*e.g., skilled nursing facility, rehabilitation hospital*) Yes No

If yes, name of institution _____

Address of institution (*number and street*) _____

Phone number _____

Your date of admission _____

4. Do you receive Medicaid benefits? Yes No

If yes, Medicaid number _____

5. Do you or your spouse work? Yes No

6. Do you have existing Part D Prescription Drug Coverage? Yes No

If yes, what was the effective date of your existing coverage? The day I became eligible for Medicare

January 1, 2006

Other (*enter date*) _____

7. Since you became eligible for Medicare, have you had any prescription drug coverage or any insurance that included drugs other than Part D? Yes No

Your answer to the following questions will not keep you from enrolling in this plan.

Section 6: Signature and Authorization

As a GOLD member: I understand that, beginning on the date my Gold coverage begins, I must get all of my health care from the Gold plan, with the exception of emergency or urgently needed services, out-of-network dialysis services or services payable under the Travel Benefit. In addition to being covered in the United States, emergency and urgently needed services are covered worldwide. I understand that services authorized by Preferred Care and other services contained in my Gold plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. I also understand that without authorization, NEITHER MEDICARE NOR PREFERRED CARE WILL PAY FOR THE SERVICES that require authorization.

OR

As a GOLDANYWHERE member: I understand that, beginning on the date my GoldAnywhere coverage begins, I may get all of my health care from GoldAnywhere network providers, or at greater costs to me, from non-network providers, with the exception of emergency or urgently needed services or out-of-network dialysis, which cost me the same regardless of whether the services are provided by a network or non-network provider. I understand that services authorized by Preferred Care and other services contained in my GoldAnywhere plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. I also understand that I am ultimately responsible for ensuring that authorization is obtained for services which require authorization and that I will incur a financial penalty when required authorization is not obtained.

By joining this plan, I attest that I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare drug plan.

Release of information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. 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 behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application, including the information on the back of this form. (Please read your Medicare Services contract to know what rules you must follow in order to receive coverage with the Preferred Care Gold or Preferred Care GoldAnywhere plan.) If signed by an authorized individual (as described above) this signature certifies that:

- This person is authorized under State law to complete this enrollment, and
- Documentation of this authority is available upon request by Preferred Care or Medicare.

PLEASE READ AND SIGN BELOW

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

Preferred Care Gold/GoldAnywhere is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. 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 do not 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. I may leave this plan only at certain times of the year, or under certain circumstances, by sending a request to Preferred Care or by calling **1-800-MEDICARE**. TTY users should call **1-877-486-2048**, 24 hours a day, seven days a week.

Signature _____ Date _____

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

Name _____ Address _____

Phone Number _____ Relationship to Enrollee _____

Send completed application to: Preferred Care Gold Sales, 259 Monroe Ave., Rochester, NY 14607

For Plan Use Only Previous ID # _____ Group Name _____ Group # _____ Effective Date _____ Input Date _____ Initials _____
 ICEP OEP AEP SEP (type): _____ OEPNEW OEPI **Date coverage should begin:** _____