

TO ENROLL IN A SAMARITAN ADVANTAGE HEALTH PLAN HMO, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Please check which plan you want to enroll in:

- Conventional Plan \$67 per month Premier Plan \$99 per month Premier Plan Plus \$121 per month

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

Birth Date: _____ Sex: _____ Home Phone Number: _____
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 (M M / D D / Y Y Y Y)

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

City: _____ State: _____ Zip Code: _____

Mailing Address (only if different from your Permanent Residence Address):
 Street Address: _____ City : _____ State: _____ ZIP Code: _____

Emergency contact (optional): _____ Relationship to You: _____ Phone Number: _____
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Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 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.

- I am new to Medicare.
- 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 have both Medicare and Medicaid or my state helps pay for my Medicare Premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drug coverage. I stopped receiving extra help on (insert date) _____.
- I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.
- I am leaving employer or union coverage on (insert date) _____.
- I recently left a PACE program on (insert date) _____.

- I was enrolled in a Specials Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP 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.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

If none of these statements applies to you or you are not sure, please contact Samaritan Advantage Health Plan HMO at (541) 768-4550 or 1-800-832-4580 (TTY 1-800-735-2900) to see if you are eligible to enroll. We are open daily 8 a.m. to 8 p.m.

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

Name: _____
 Medicare Claim Number _____ Sex _____
 _____ - _____ - _____
 Is Entitled To _____ Effective Date _____
 HOSPITAL (Part A) _____
 MEDICAL (Part B) _____

Office Use Only: Plan ID #: _____ Effective Date of Coverage: _____
 ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____
 Name of staff member/agent/broker (if assisted in enrollment): _____

PAYING YOUR PLAN PREMIUM

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) **by mail, credit or debit card, or Electronic Funds Transfer 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 are assessed a Part D-Income related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying 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 Samaritan Advantage Health Plan HMO the Part D-IRMAA. 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/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 bill monthly
- Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:
 Account holder name: _____
 Account type: Checking Saving
 Bank routing number: _____
 Bank account number: _____
- Credit or debit card. If you select this option, the plan will contact you.
- Automatic deduction from your 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.)

PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS:

1. **Do you have End-Stage Renal Disease (ESRD)?** Yes No If you have had a successful kidney transplant and/or you do not need regular dialysis anymore, **please attach a note or records from your doctor** showing you have had a successful kidney transplant or you do not need dialysis, otherwise we may need to contact you to obtain additional information.

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 Samaritan Advantage Health Plan HMO? 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 5. **Do you or your spouse work?**
 If yes, please provide your Medicaid number: _____ 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: Spanish Large print
 Please contact Samaritan Advantage Health Plan HMO at (541) 768-4550 or 1-800-832-4580 if you need information in another format or language than what is listed above. Our office hours are daily from 8 a.m. to 8 p.m. TTY users should call 1-800-735-2900.

******* PLEASE READ THE BACK PAGE OF THIS DOCUMENT AND SIGN BELOW: *******

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.

Signature: _____ **Today’s Date:** _____
If you are the authorized representative, you must sign above and provide the following information:
 Name: _____ Phone Number: (_____) _____ - _____
 Address: _____ Relationship to Enrollee: _____

STOP! PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining Samaritan Advantage Health Plan HMO could affect your employer or union health benefits. You could lose your employer or union health coverage if you join a Samaritan Advantage Health Plan HMO. Read the communications your employer or union sends you. If you have questions, visit their web site 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.

BY COMPLETING THIS ENROLLMENT APPLICATION, I AGREE TO THE FOLLOWING:

Samaritan Advantage Health Plan HMO 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.

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

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

Samaritan Advantage Health Plan HMO

YOUR ADVANTAGE

2012 Individual Enrollment Request Form

Please contact Samaritan Advantage Health Plan HMO if you need information in another language or format

Samaritan Advantage Health Plan HMO

Sales agent line: 1-866-747-5267 (1-866-SHPlans)

Monday–Friday, 8:30 a.m. to 5 p.m.,

815 NW Ninth Street, Suite 101, Corvallis

Mailing Address: P.O. Box M, Corvallis OR 97339

Customer Service, daily 8 a.m. to 8 p.m. : (541) 768-4550, 1-800-832-4580 (TTY 1-800-735-2900)

www.samhealth.org/SHPlans

