



ENROLLMENT FORM

Name of Plan you are enrolling in: _____

Name		Medicare Number		
		(Note: May use Member ID# instead of Medicare number)		
Home Phone Number (XXX-XXX-XXXX)		Alternate Phone Number (XXX-XXX-XXXX)		
Permanent Street Address (Number, Street, Apt. #)	City	County	State	Zip
Mailing Address (only if different from permanent address)	City	County	State	Zip

Please Fill Out the Following

I am currently a member of the _____ plan in Puget Sound Health Partners (PSHP) with a monthly premium of \$_____.

I would like to change to the _____ plan in PSHP. I understand that this plan has different health benefits and a monthly premium of \$_____.

I would like to add optional supplemental coverage to my Medicare Advantage plan. I understand that the premium for optional supplemental coverage is in addition to my plan premium.

Please check the optional supplemental coverage(s) you would like to enroll in:

- Alternative \$3 per month
- Dental \$37 per month

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:

- Language: _____
- Format: (like Braille, audio tape or large print) _____

Please contact PSHP at 1-866-789-7747 (TTY users should call 1-866-264-4141) if you need information in another format or language than what is listed above. Our office hours are 8 a.m. to 8 p.m., 7 days a week.



Please Read the Important Information on Back BEFORE signing!

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 by PSHP or by Medicare.

Your Signature: _____ **Date** _____

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

Signature: _____ **Date:** _____

Name: _____ **Relationship to Enrollee:** _____

Address: _____ **Phone:** _____

Please Read This Important Information Before Signing!

PSHP is a plan that has a contract with the Federal government. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with PSHP he/she may be paid based on my enrollment in PSHP.

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. I also acknowledge that PSHP 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 PSHP. I understand that people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date PSHP coverage begins, I must get all of my health care from PSHP physicians except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by PSHP and other services contained in my PSHP Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR PSHP WILL PAY FOR THE SERVICES.**

By joining this plan, I confirm that I am not getting any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) to buy medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage plan or Medicare Drug Plan.

SIGNATURE REQUIRED ON FRONT OF THIS FORM AFTER READING THE ABOVE

Office Use Only

Name of staff member/agent/broker (if assisted in enrollment)		Name of PCP				
Plan ID#	Member ID#			POD#		
Effective date of coverage	ICEP	IEP	OEP	AEP	SEP (type)	Not Eligible