Senior Plus (HMO)

HMO

Medicare Advantage HMO
Employer/Union Group Health Plan
Enrollment Request Form

Health Alliance Plan
2850 W. Grand Blvd., Detroit, MI 48202
Telephone (800) 868-3153
TTY: 711

Please contact HAP Senior Plus (HMO) if you need information in another language or format (large print).

To enroll in HAP Senior Plus (HMO), Please Provide the Following Information

Employer or Union Name:	Group Number (If known. If not leave blank):
Wayne State University	1000064-1006

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

Birth Date:	Sex:	Home Phone Number:
(___ ___/___ ___/___ ___ ___ ___)	☐ M ☐ F	( ) _____
M M/D D/Y Y Y Y		Email:

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

City: _____ State: _____ ZIP Code: _____ County:

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

Street Address: _____ City: _____ State: _____ ZIP Code: _____

Emergency Contact: _____ **Relationship to You:** _____

Phone Number: _____

Please Provide Your Medicare Insurance Information

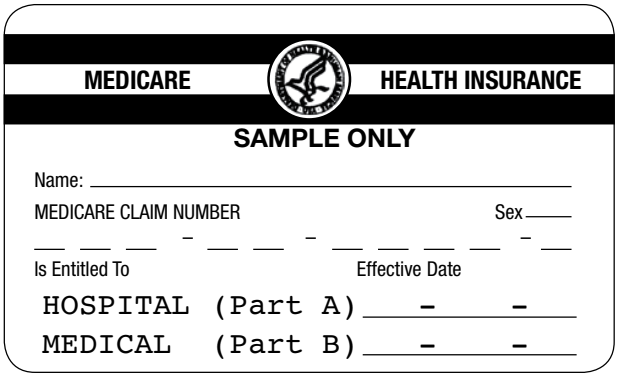
Please take out your Medicare card to complete this section.

- 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.



Please read and answer these important questions:

1. Are you the retiree? ☐ Yes ☐ No

   If yes, retirement date (month/date/year): _____

   If no, name of retiree: _____

2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No

   If yes, name of spouse: _____

   Name(s) of dependent(s): _____

3. Do you or your spouse work? ☐ Yes ☐ No

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

   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensative, VA benefits, or State pharmaceutical assistance programs.

   Will you have other prescription drug coverage in addition to HAP Senior Plus? ☐ 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_____

6. 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): _____

   _____

Please choose the name of a Primary Care Physician (PCP), clinic or health center:

Medical Center Name: _____

Primary Care Physician Name: _____

Primary Care Physician ID #: _____

Please check one of the boxes below if you would prefer us to send you information in another format:

☐ Large print

☐ Audio tape

Please contact HAP Senior Plus at (800) 868-3153, if you need information in another format than what is listed above. Our office hours are Monday through Friday, 8 a.m. to 5 p.m. TTY/TDD users should call TTY: 711.

Please Read and Sign Next Page

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

HAP Senior Plus 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.

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

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare heath plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that HAP Senior Plus 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 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: _____

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: _____