2019 Individual Enrollment Request Form

Please contact IU Health Plans if you need information in another language or format.

Return completed form to:
Enrollment Department
Indiana University Health Plans
950 N. Meridian St., Suite 400
Indianapolis, IN 46204

To enroll in IU Health Plans please provide the following information

Check the appropriate plan you want to enroll in. **Please verify the plan is offered in the county that you live in.**

❑ Indiana University Health Plans Medicare Select HMO 002 (no RX) – $0

❑ Indiana University Health Plans Medicare Select Plus HMO 009-001 – $46

❑ Indiana University Health Plans Medicare Select Plus HMO 009-002 – $0

❑ Indiana University Health Plans Medicare Select Plus HMO 009-003 – $0

❑ Indiana University Health Plans Medicare Choice HMO POS 004 – $98

OPTIONAL

To add an optional supplemental dental benefit plan, check ONLY ONE box from the options below. Optional supplemental dental premium will be in addition to your monthly medical premium.

❑ Dental Basic 750 – $6 per month

❑ Dental Enhanced 1000 – $12 per month

❑ Dental Enhanced 1500 – $18 per month

Proposed coverage start date:
_____ – 01 – 2019

First name:	Last name:	Middle initial:	❑ Mr. ❑ Mrs. ❑ Ms.
Birth date (MM/DD/YYYY):		Sex: ❑ M ❑ F	Home phone number:
Permanent residence street address (P.O. Box is not allowed):			County:
City:		State:	ZIP:
Mailing address (only if different from your permanent residence address): Street address:			
City:		State:	ZIP:
(Optional) Email address: By providing your email address you are agreeing to receive emails about your benefits, plan updates and other plan services. You may opt-out of this email option at any time.			
Please choose the name of an in-network primary care provider (PCP): Current patient (check one): ❑ Yes ❑ No Office location:			
(Optional) Emergency contact (not living with you): Phone number:		Relationship to you:	

RETURN WHITE COPY. YELLOW COPY – APPLICANT KEEP FOR YOUR RECORDS.

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Health Plans

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Please check the box below if you would prefer us to send you information in an accessible format or language other than English:

❑ Large print ❑ Request for language other than English, language preference: _____

Please contact IU Health Plans Customer Solutions Center at 317.963.9700, toll free at 800.455.9776 (TTY only, call Relay Indiana at 800.743.3333) if you need information in an accessible format or language other than what is listed above. Our hours are 8 am to 8pm, seven days a week, from Oct. 1 to March 31. April 1 – Sept. 30, a representative will be available from 8 am to 8 pm, Monday – Friday.

Please provide your Medicare insurance information

Please take out your red, white and blue Medicare card to complete this section—OR—attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):	Medicare number:
Part A (Hospital) effective date ____ / ____ / ____	Part B (Medical) effective date ____ / ____ / ____

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

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 by mail "Electronic Funds Transfer (EFT)" or credit card each month. You can also 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 the RRB. Do NOT pay Indiana University Health Plans the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75 percent or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify 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 800.772.1213. TTY users should call 800.325.0778. You can also apply for Extra Help online at **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 for this benefit. 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 one option below:

❑ **Get a bill**

❑ **Electronic funds transfer (EFT) from your bank account on the 3rd day of each month.**

Account holder name: _____

Bank name: _____

Bank routing number: ☐☐☐☐☐☐☐☐☐ Bank account number: _____

Account type: ❑ Checking ❑ Savings

❑ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.**

I get monthly benefits from: ❑ Social Security ❑ RRB

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Note: 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.

Note: EFT may take two months to begin and in this case we will send you a premium notice for the month(s) prior to the deduction start date.

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 don't need regular dialysis anymore, 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.

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 IU Health Plans? ❑ 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 facility:

Address and phone number of facility (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

Do you or your spouse have other health insurance that will cover medical services? (Examples: Other employer group coverage, LTD coverage, Worker's Compensation, Auto Liability, or Veteran's benefits)
❑ Yes ❑ No

If yes, please complete the following:

Name of health insurance company: _____

Subscriber name: _____ Group ID number: _____

Member ID number: _____ Effective Dates (if applicable): _____

If you have questions or need assistance in completing this application, please contact IU Health Plans Customer Solutions Center at 317.963.9700, toll free at 800.455.9776 (TTY only, call Relay Indiana at 800.743.3333). From Oct. 1 – March 31, Customer Solutions Center hours are 8 am to 8 pm, seven days a week. April 1 – Sept. 30, a representative will be available from 8 am to 8 pm, Monday – Friday.

Indiana University Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Indiana University Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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Indiana University Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact IU Health Plans Customer Service at 800.455.9776 and ask for the Civil Rights Coordinator.

If you believe that Indiana University Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Indiana University Health Plans, 950 N. Meridian St., Suite 400, Indianapolis, IN 46204; 800.455.9776, TTY: 800.743.3333; Fax 317.963.9801; HealthPlansCompliance@iuhealth.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the IU Health Plans Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf,** or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Ave. SW
Room 509F, HHH Building
Washington, DC 20201
800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at **hhs.gov/ocr/office/file/index.html.**

IU Health Plans cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

IU Health Plans 遵守適用的聯邦民權法律規定，不因種族、膚色、民 族血統、年齡、殘障或性別而 歧視任何 人.

STOP – Please read this important information

If you currently have health coverage from an employer or union, joining IU Health Plans could affect your employer or union health benefits. You could lose your employer or union coverage if you join IU Health Plans. 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 no contact information is listed, your benefits administrator or the office that answers questions about your coverage can help.

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Please read and sign below

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

Indiana University Health Plans is a Medicare Advantage organization with a Medicare contract. Enrollment in Indiana University Health Plans depends on contract renewal. Other pharmacies/physicians/providers are available in our network. Product types include HMO and HMO POS. 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: Oct. 15 – Dec. 7 of every year), or under certain special circumstances.

IU Health Plans serves a specific service area. If I move out of the area that IU Health Plans 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 IU Health Plans, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from IU Health Plans 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 IU Health Plans coverage begins, I must get all of my healthcare from IU Health Plans providers, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by IU Health Plans and other services contained in my IU Health Plans Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Certain services require prior authorization. Without authorization, NEITHER MEDICARE NOR IU HEALTH PLANS WILL PAY FOR SERVICES. I can call a plan representative for assistance in determining which services require authorization.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with IU Health Plans, he/she may be paid based on my enrollment in IU Health Plans.

Release of information: By joining this Medicare health plan, I acknowledge that IU Health Plans will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that IU Health Plans will release my information, including any 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: Phone number: Relationship to enrollee:

Address:

Office and agent use only

Name of agent/broker: **Agent #:** ☐☐☐☐

❑ ICEP/IEP ❑ AEP ❑ SEP type (see next page):

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Special Enrollment Periods Types

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from Oct. 15 through Dec. 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 am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ❑ 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 recently was released from incarceration. I was released on (insert date) _____.
- ❑ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ❑ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ❑ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date)_____.
- ❑ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- ❑ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ❑ 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 recently left a PACE program 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 am leaving employer or union coverage on (insert date)_____.
- ❑ I belong to a pharmacy assistance program provided by my state.
- ❑ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ❑ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.
- ❑ I was enrolled in a Special 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 was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact IU Health Plans at 317.963.9700, toll free at 800.455.9776 (TTY users should call Relay Indiana at 800.743.3333) to see if you are eligible to enroll. We are open from Oct. 1 – March 31, 8 am to 8 pm, seven days a week. April 1 – Sept. 30, we are open from 8 am to 8 pm, Monday – Friday.