Medicare Advantage Enrollment Election Form

Vantage Health Plan, Inc.
130 DeSiard Street, Suite 300
Monroe, LA 71201

(318) 361-0900 TTY (318) 361-2131
(866) 704-0109 TTY (866) 524-5144
Medicare Enrollment Fax (318) 807-1115

Vantage Medicare Advantage

Please contact Vantage Health Plan, Inc. if you need information in another language or format.

To enroll in Vantage Medicare Advantage, please provide the following information:

Please check the Vantage plan you want to enroll in:

___ Vantage Basic (HMO-POS) $0.00 per month

___ Vantage Standard (HMO-POS) $59.00 per month

___ Vantage Premium (HMO-POS) $169.00 per month

Last Name	First Name	Middle Initial	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: __ __ / __ __ / __ __ __ __ (Month / Day / Year)	Sex: ☐ M ☐ F	Cell Phone Number: (_____)_____-_____	Home Phone Number: (_____)_____-_____

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

City:	Parish:	State:	ZIP Code:

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

Street: City: State: ZIP Code:

Email Address:

Emergency Contact: _____

Phone Number: _____ **Relationship to you:** _____

Please Provide your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

► Fill out this information as it appears on your Medicare card.

-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: _____

Is Entitled to: Effective Date:

HOSPITAL (Part A) __ __ - __ __ - __ __ __ __

MEDICAL (Part B) __ __ - __ __ - __ __ __ __

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

Paying Your Plan Premium

Basic Plan Only: 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/debit card each month, or by prepaying quarterly or annually. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

For all other Plans: You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, electronic funds transfer (EFT), or credit/debit card each month, or by prepaying quarterly or annually. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

For all Plans:
If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), 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 Vantage Medicare Advantage 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 coinsurance. 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 does not cover.

If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

☐ Receive a bill: ☐ Monthly ☐ Quarterly (prepay only) ☐ Annually (prepay only)

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a *VOIDED* check or provide the following:

Account holder name: _____

Bank routing number: _____

Bank account number: _____

Account type: ☐ Checking ☐ Saving

☐ Credit/Debit Card. Please provide the following information:

Type of Card: _____

Name of account holder as it appears on card: _____

Account number: __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __

Expiration Date: __ __ / __ __ __ __
Month Year

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

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security or 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 any more, **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 Vantage Medicare Advantage? ☐ Yes ☐ No

   If "yes" please list your other coverage and your identification (ID) number(s) for the other 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 & 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

Please choose and enter the name of a Medical Home-Primary Care Provider (MH-PCP):

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

☐ Digital Documents (Online documents instead of paper documents)

☐ Large Print

Please contact Vantage Medicare Advantage at (866) 704-0109 if you need information in another format or language than what is listed above. Our office hours are Monday through Friday from 8:00 a.m. – 8:00 p.m. TTY users should call (866) 524-5144.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Vantage Medicare Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Vantage Medicare Advantage. Read the communications your employer or union sends you. If you have any 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.

Attestation of Eligibility

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 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 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 drugs. 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 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 Special Needs Plan (SNP) but I have lost my special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

If none of these statements applies to you or you are not sure, please contact Vantage Medicare Advantage at (318) 361-0900 or toll-free at (866) 704-0109 (TTY users should call (318) 361-2131 or toll-free TTY (866) 524-5144) to see if you are eligible to enroll. Member Services is available seven days a week, 8:00 a.m. – 8:00 p.m. CST, from October 1, 2017 through February 14, 2018. After February 14, 2018, Member Services will operate five days a week, Monday – Friday, 8:00 a.m. – 8:00 p.m. CST.

Please read and sign below

By completing this enrollment application, I agree to the following: Vantage Medicare Advantage 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. 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.

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

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

Vantage continually pursues quality improvement ("QI") for its membership, along with offering case management services. In connection therewith, I authorize Vantage, for treatment and operations purposes, to release medical and non-medical information to any party contracted by Vantage to render QI and/or case management related services.

I understand that my signature (or the signature of the person authorized to act on my behalf under the law 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:

Name:_____ Relationship to Enrollee: _____

Address: _____ Phone Number: _____

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Broker Name _____ Company Name: _____

Date Application Was Accepted/Received by staff member/agent/broker: _____

Effective Date of Coverage: _____ Plan Enrolled Into:_____

AEP: _____ ICEP/IEP*: _____ SEP*(type): _____ Not Eligible: _____

Meeting ___ Home Visit ___ Date(meeting/home visit): _____

***Must complete Attestation of Eligibility for all enrollments outside of AEP**