

Office Use Only:

Member ID # _____
 Effective Date of Coverage: _____
 ICEP/IEP: _____ OEP: _____ AEP: _____
 SEP (type): _____ Not Eligible: _____
 PBP _____
 Tran. Code _____
 Plan #: _____
 Premiums _____
 Group # _____

Providence Medicare Plans
**Enrollment
 Request Form**



PO Box 5548
 Portland, OR 97228-5548
 1-800-603-2340

Please check which plan you want to enroll in:

- Providence Medicare Extra Plan 1 + RX
 Providence Medicare Extra Plan 1
 Providence Medicare Choice + RX
 Providence Medicare Choice

Enrollee Information

Mr. Mrs. Ms.

LAST name: _____ FIRST name: _____ Middle Initial _____

Birth Date: (__ __ / __ __ / __ __ __ __) Sex: _____ Social Security Number: _____
 (M M / D D / Y Y Y Y)

Permanent Residence

Street Address: _____

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

Home Phone Number: _____ E-mail Address: _____

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

Address: _____

City: _____ State: _____ ZIP: _____

Emergency contact: _____

Relationship to You: _____ Phone Number: _____

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 the Social Security Administration or Railroad Retirement Board.

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

 Health Insurance	
SOCIAL SECURITY ACT	
NAME OF BENEFICIARY (your name) SAMPLE	
CLAIM NUMBER	SEX
IS ENTITLED TO	EFFECTIVE DATE
Hospital Insurance (Part A)	_____
Medical Insurance (Part B)	_____

Information to Determine Enrollment Periods

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you do not change your prescription drug coverage. Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

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.
- I recently moved and this plan is a new option for me.
- I have both Medicare and Medicaid or my state helps pay for my Medicare Premiums.
- I receive extra help paying for Medicare prescription drug coverage.
- I am no longer eligible for extra help paying for my Medicare prescription drugs.
- I live in or recently moved out of a Long Term Care Facility (for example, a nursing home or long term care facility).
- I recently left a PACE program.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
- I am leaving employer or union coverage.
- 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.
- None of these statements applies to me.*

*Please contact Providence Medicare Plans at 1-800-457-6064 (TTY users should call 1-888-244-6642) to see if you are eligible to enroll. We are open seven days a week from 8 a.m. to 8 p.m.

Paying Your Plan Premium

You can pay your monthly plan premium by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security check each month.

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 do not select a payment option, you will receive a bill each month.

Please select a premium payment option:

- Receive a monthly bill
- Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check and provide the following:
Account holder name: _____
Bank routing number: _____ Bank account number: _____
Account type: Checking Savings
- Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please read and answer these important questions:

1. Have you previously been a Providence Medicare Plans member? Yes No
2. Do you have End Stage Renal Disease (ESRD)? Yes No
If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant.

3. 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 health insurance coverage in addition to Providence Medicare 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: _____

Will you have other prescription drug coverage in addition to Providence Medicare 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: _____

4. 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: _____ Phone: _____

Address of Institution (number and street): _____

5. Are you enrolled in your State Medicaid program? Yes No

If yes, please provide your Medicaid number: _____

6. Do you or your spouse work? Yes No

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 Audio CD

Please contact Providence Medicare Plans at 1-800-457-6064 (TTY users should call 1-888-244-6642) if you need information in another format or language than what is listed above. Our office hours are from 8 a.m. to 8 p.m., seven days a week.

Primary Care Provider (First and Last Name) _____

Established Patient? Yes No

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Providence Medicare Plans could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Providence Medicare Plans may change how your current coverage works. 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 there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign

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

Providence Medicare Plans is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my 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 do not have Medicare prescription drug coverage, or a creditable prescription drug coverage plan (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: November 15 – December 31 of every year), or under certain special circumstances, by sending a request to Providence Medicare Plans or by calling 1-800-Medicare. TTY users should call 1-877-486-2048, 24 hours a day/7 days a week.

Providence Medicare Plans serves a specific service area. If I move out of the area that Providence Medicare 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 Providence Medicare Plans, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Member Handbook/Evidence of Coverage from Providence Medicare Plans when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in urgent or emergent situations. See Summary of Benefits for further information.

I understand that beginning on the date Providence Medicare Plans coverage begins, I must get all of my health care through Providence Medicare Plans, with the exception of emergency or urgently needed services, out-of-area dialysis services. Services authorized by Providence Medicare Plans and other services contained in my Providence Medicare Plans Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR PROVIDENCE MEDICARE PLANS WILL PAY FOR THE SERVICES. Some exceptions apply to members of Providence Medicare Choice.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Providence Medicare Plans, he/she may be compensated based on my enrollment in Providence Medicare Plans.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

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 Providence Medicare Plans will release my information including my prescription drug event data if I am on a prescription drug plan 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 behalf of the individual under the laws of the State where the individual resides) 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 Providence Medicare Plans or by Medicare.

Your 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 _____

Agent Name (If applicable) _____