# Retiree Group Health Plan Enrollment Request Form

scan HEALTH PLAN®

Please contact SCAN Health Plan® if you need any information in another language or format. (Braille)

Step 1: Please fill out the application completely. Use a ballpoint pen and press hard to make two copies.

Step 2: Sign and date the application.

Step 3: Keep the BOTTOM copy for your file.

If you have any questions regarding this application, please call 1-877-212-7654 (TTY: 711). Hours are 8 A.M. to 8 P.M., 7 days a week from October 1 to March 31. From April 1 to September 30 hours are 8 A.M. to 8 P.M., Monday through Friday. Messages received on holidays and outside of our business hours will be returned within one business day.



## 1 To Enroll in SCAN Health Plan, Please Provide the Following Information:

| Retiree Group Name: | Group Number: |
|---|---|

Last Name: _____ First Name: _____ M.I.: _____

Birth Date: _____/_____ /_____ Sex: ☐ Male ☐ Female
MM DD YYYY

Phone #: (_____)_____ Email Address: _____

**Please choose how you want to receive plan information:**

☐ Check here to get your Part C Explanation of Benefits (EOB) and Annual Notice of Change (ANOC) online, rather than by U.S. mail. You will receive an e-mail each time one of these documents is available. You can change back to U.S. mail at any time.

**Permanent Residence Street Address** (PO Box is not allowed):

_____

City: _____ State:_____ Zip Code:_____

**Mailing Address, (PO Box is allowed)** (only if different from your Permanent Residence Address):

Street Address: _____

City: _____ State:_____ Zip Code:_____

**Emergency Contact** *(optional):* _____

Phone Number: (_____)_____Relationship to You: _____

**Please check one of the boxes below if you want plan information in a language other than English:**

Language: ☐ Spanish ☐ Other format content _____

**Select one if you want us to send you information in an accessible format.** ☐ Braille ☐ Spanish ☐ Audio CD

Please contact SCAN Health Plan at 1-877-212-7654 (TTY: 711) if you need information in an accessible format (like audio or large print) or a language other than those listed above. Hours are 8 A.M. to 8 P.M., 7 days a week from October 1 to March 31. From April 1 to September 30 hours are 8 A.M. to 8 P.M., Monday through Friday. Messages received on holidays and outside of our business hours will be returned within one business day.

**Social Security:** ☐☐☐ - ☐☐ - ☐☐☐☐

## 2 Please Provide Your Medicare Insurance Information

| Please take out your red, white and blue Medicare card to complete this section.<br>• Fill out this information as it appears on your Medicare card. | Name (as it appears on your Medicare card):<br>Medicare Number: |
|---|---|

## 3 Physician Information

**Please choose a Primary Care Physician (PCP), and Medical Group.**

| Physician Name: | Physician ID Number: |
|---|---|
| Medical Group Name: | Group ID Number: |

Is this a new physician for you? ☐ Yes ☐ No

## 4 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): _____
   ** A separate application is required for a spouse or dependent for enrollment in SCAN Health Plan.

3. Do you work? ☐ Yes ☐ No
   Does 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 Compensation, VA benefits or state pharmaceutical assistance programs. ☐ Yes ☐ No
   Will you have other <u>prescription</u> drug coverage in addition to SCAN Health Plan?
   If "yes" please provide the following information:
   Name of other coverage:_____
   ID # for other coverage: _____

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. Please call SCAN Member Services at 1-800-559-3500. TTY: 711.

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 RRB. DO NOT pay SCAN Health Plan the Part D-IRMAA. For more information about contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users call 1-800-325-0778.

## 5 Please Read and Sign Below

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

SCAN Health Plan 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.

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

**Release of Information:** By joining this Medicare health plan, I acknowledge that SCAN will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that SCAN 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:_____ Relationship to enrollee:_____

Address:_____

Phone number: (_____)_____

**OFFICE USE ONLY**

| NAME OF STAFF MEMBER/AGENT/BROKER (if assisted in enrollment): | NATIONAL PRODUCER NUMBER (NPN): |
|---|---|
| ENROLLEE'S PREFERRED SPOKEN LANGUAGE (IF OTHER THAN ENGLISH): | |

| EFFECTIVE DATE OF COVERAGE ___ ___ /___ ___ /___ ___ ___ ___ (M M / D D / Y Y Y Y) | ICEP/IEP ❑ | AEP ❑ | SEP (TYPE) ❑ _____ | NOT ELIGIBLE ❑ | REC'D DATE: |
|---|---|---|---|---|---|
| | CHECK THE APPROPRIATE BOX(ES) ABOVE | | | | |

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