

RETIREE GROUP HEALTH PLAN ENROLLMENT REQUEST FORM



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

STEP 1: Please fill out the application completely.

STEP 2: Sign and date the application.

If you have any questions regarding this application, please call 1-844-722-4424 (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. (optional)	
Birth Date:		Sex: ☐ Male ☐ Female	
Phone Number: () -		Mobile Phone Number: () -	

By providing your cell number, you are opting in to receive direct and automated plan communications via SMS text messages. If you do not wish to receive any plan communications or updates via text message, check this box ☐ Opt Out

Permanent Residence Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

Street Address:		Apt/Unit:	
City:		State:	
ZIP Code:			
Mailing Address (only if different from your Permanent Address):			
Street Address:		Apt/Unit:	
City:		State:	
ZIP Code:			
Emergency Contact: (optional)			
Phone Number: () -		Relationship to You:	

2 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.	Name (as it appears on your Medicare card):
	Medicare Number:
Social Security:	

1.	Are you the retiree? If yes, retirement date (month/date/year): _____ If no, name of retiree: _____	☐ Yes ☐ No
2.	Are you covering a spouse or dependents under this employer or union plan? 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.	☐ Yes ☐ No
3.	Do you work? Does your spouse/partner work?	☐ Yes ☐ No ☐ Yes ☐ No
4.	Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to SCAN Health Plan? If "yes" please provide the following information: Name of other coverage: _____ ID # for other coverage: _____	☐ Yes ☐ No
5.	Are you a resident in a long-term care facility, such as a nursing home? If "yes" please provide the following information: Name of Institution: _____ Address & Phone Number of Institution (number and street): _____ _____	☐ Yes ☐ No
6.	I qualify to enroll into a Chronic Special Needs Plan	☐ Yes ☐ No
7.	Do you have end-stage renal disease (ESRD)? Are you currently on dialysis??	☐ Yes ☐ No ☐ Yes ☐ No

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.

Physician Information

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

I do not have a preferred primary care physician. Please auto assign to a contracted SCAN primary care physician. ☐ Yes ☐ No

Physician Name:

Physician ID Number:

Medical Group Name:

Group ID Number:

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Are you a current patient of this physician? ☐ Yes ☐ No

Answer these important questions:

The fields in this section are optional. Answering these questions is your choice. You can't be denied coverage you don't fill them out.

Email Address: _____

I want to get the following materials via email.

By providing my email address, I agree to receive electronic communication, when available.If you would like to opt out of electronic communications check this box ☐ Opt Out

Phone Number: () -

By providing my number, I agree to receive automated and/or other text messages by SCAN Health Plan for healthcare, benefits, or any other purpose. Such consent is not a condition of receipt of any service and I can opt out at any time. Message and data rates may apply.

Language Preferences:

Select one if you want us to send you information in a language other than English:

☐ Spanish ☐ Chinese ☐ Korean ☐ Vietnamese

What is your preferred spoken language if other than English:

☐ Spanish ☐ Chinese ☐ Korean ☐ Vietnamese ☐ Other

Select one if you want us to send you information in an accessible format: ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact SCAN Health Plan at 1-800-531-4040 (TTY: 711) if you need information in an accessible format (like audio or large print) or a language other than those listed above. Our office hours are 8:00 a.m. to 5:00 p.m. PST Monday through Friday. TTY users call 711.

Payer-to-Payer Data Sharing

We can securely share health information with your current or former health plans to help coordinate your care, reduce delays, and maintain a complete health record. Your information will only be shared if you choose to opt in, and you can change your choice at any time. Please refer to scanhealthplan.com for more information.

☐ **Opt in** – I authorize SCAN to securely request and share my health information with my current or former health plans.

- I must keep both Hospital (Part A) and Medical (Part B) to stay in SCAN Health Plan.
- By joining this Medicare Advantage Plan, I acknowledge that SCAN Health Plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my SCAN Health Plan coverage begins, I must get all of my medical and prescription drug benefits from SCAN Health Plan. Benefits and services provided by SCAN Health Plan and contained in my SCAN Health Plan “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor SCAN Health Plan will pay for benefits or services that are not covered.
- 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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 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: (____) _____

FOR INDIVIDUALS HELPING ENROLLEE WITH COMPLETING THIS FORM ONLY

Complete this section if you are an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name:	Relationship to Enrollee:	Signature:
Effective Date of Coverage:	Rec'd Date	National Producer Number (NPN):
/ / MMDDYYYY		