

2013 Medicare Advantage Prescription Drug Plan (MAPD) Individual Enrollment Form

Please contact SummaCare Secure if you need information in another language or format (Braille).							
To Enroll in SummaCare Secure Please Provide the Following Information:							
Please check which plan you want to enroll in:							
□ CORE	□ SILVER				GOLD		
(HMO) (\$0/month)				nth)		IMO-POS) (\$134/month)	
	AL: 🗖 Delta D						
By checking the box							
I understand that I will have to pay SummaCare an additional \$25 in premium for this plan.							
Effective Date: The date you want coverage to begin. In general, requests to enroll will be effective on the first day of the month after this form is received Month Year						nective on the first day of the	
LAST Name:	FIRST Name:		Middle Initia	dle Initial:			
LAOT Name.	TINOT Name.	ino i name.			. 4 1/11/3. 4 1/13.		
Birth Date:	Sex:	Home Phone Number:			Alterr	Alternate Phone Number:	
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Permanent Residence Street Addre		l not allow	rad)·				
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City:	OHIO	County:				ZIP Code:	
Mailing Address (Only if different fro			ence Addi	ess)		Zii oodo:	
Street Address or Post Office Box:	,			/			
City:		State:				ZIP Code:	
☐ Emergency Contact or		Phone Number: ( )				Your E-mail Address:	
□ Power of Attorney (POA)		Relationship to You:			_		
Name:							
	lease Provide		dicare Ins	urance Infor	mation		
Please take out your Medicare card to	complete this	section.		MEDIC	ARE	HEALTH INSURANCE	
Please fill in the blanks to the right	nt so they matc	h your					
red, white and blue Medicare car	d				SAMPLE	UNLY	
- OR -			Name	):		<del> </del>	
		•	Medio	care Claim Nu	ımber:	Sex:	
Attach a copy of your Medicare c	,					_	
Social Security or the Railroad Retirement Board.			Is En	Is Entitled To Effective Date			
You must have Medicare Part A and F	Part B to join a		HOSF	PITAL (PART	A)		
Medicare Advantage Plan.			MEDI	CAL (PART E	3)		

## Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by any of the following methods: You can receive a paper invoice in the mail each month and mail SummaCare a check for the premiums due. You can pay your bill automatically each month from a checking or savings account using Electronic Funds Transfer. You can pay your bill automatically each month using a VISA or MasterCard. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. No matter which method you select, you must continue to pay your Part B premiums to Social Security in addition to the SummaCare plan premiums.

If you previously qualified for Medicare prescription drug coverage, but decided not to carry prescription coverage at least as good as Medicare's, then Medicare may determine that you owe a monthly Late Enrollment Penalty.

If Medicare informs SummaCare that you owe this late enrollment penalty, it will be included in your monthly premium, even if you sign up for a \$0 premium plan. If it is determined that you owe a late enrollment penalty, we need to know how you would prefer to pay it.

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 the RRB. DO NOT pay SummaCare 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% 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 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 have recently been enrolled in Medicaid or you have received a letter stating that you have qualified for Qualified Medicare Beneficiary (**QMB**) or Specified Low-Income Medicare Beneficiary (**SLMB**) status, you automatically qualify for Prescription Drug Assistance. If you need a prescription filled <u>before</u> SummaCare receives confirmation from the Centers for Medicare and Medicaid Services (CMS) of your eligibility status, please contact our Customer Service Department for assistance. The qualifications for Prescription Drug Assistance are based on income and assets. If you do qualify, Medicare would pay for a portion of your total monthly premium. SummaCare would bill you for the balance of your premium.

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 doesn't cover.

Please select a premium paym (If you don't select a payment option, we will r	
Get a monthly bill in the mail.	
Electronic funds transfer (EFT) from your bank account each mossible and provide the following:	onth. Please enclose a VOIDED check if U.S. Checks
Account Holder Name:  Bank Routing Number:	PAYTO DATE
Bank Account Number:	ADMIC CITY, STATE, 22P SAME PROME FOR \$123456789\$  0123456789012 1001
Account Type:   Checking   Savings	Bank Routing Bank Account Number Number

☐ Electronic charge to your VISA or MasterCard each month. Please provide the following:	
Credit Card Type:   VISA   MasterCard	
Name of Account Holder as it appears on card:	
Account Number:	
CVV Number (3-digit code on the back of your card): Expiration Date (MM/YYYY):	
□ *Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.	
<u>PLEASE NOTE</u> : The Social Security deduction may take <u>two or more months to begin</u> after Social Security or RRB approved deduction. Usually, the effective date of the deduction will NOT be the same as your enrollment effective date with Summa Summa Care will send you a monthly bill in the mail until we receive notification from Medicare as to which month they be taking the money out of your Social Security check. You are responsible for paying by check until such time as we have established the effective date of your withhold.	aCare.
*You should know that Social Security <b>LIMITS</b> the automatic deduction amount allowed from your benefit check to \$200. example, should you select the SummaCare Secure Gold plan and there is a two month delay in processing, the entire transaction will be rejected by Social Security because the deduction amount would exceed \$200. You will then default be being billed by mail for all unpaid premiums.	
Please read and answer these important questions:	
1. Do you have End Stage Renal Disease (ESRD)?	
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 <u>prescription</u> drug coverage in addition to SummaCare? □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 Institution: Address & Phone Number:	
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 your Primary Care Physician (PCP). You may search the SC <i>Secure</i> Provider/Pharmacy Directory or search online at www.medicare.summacare.com and click on "Find Your Doctor or Hospital":	
Name: PCP Code:	

If you or someone you know would benefit from having our information in a language other than English OR in another format such as large print, audiotape or Braille, please contact SummaCare Secure Sales at 888-464-8440 (TTY 800-750-0750). A representative will be available to speak with you from 8 a.m. to 8 p.m. seven days a week.



## Please Read This Important Information

If you have health coverage from an employer or union that you are going to be keeping, joining SummaCare may change how that coverage works. Please contact the Benefits Administration office at your former employer if you have questions about how these two insurances will work together.

## Please Read and Sign Below:

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

SummaCare 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 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.

SummaCare serves a specific service area. If I move out of SummaCare's service area, I will need to enroll in a new plan for my new area. I understand that SummaCare provides medical and prescription drug coverage when I travel and I will have emergency coverage if I travel outside of the U.S. I understand that the Evidence of Coverage I receive will tell me what benefits I have under SummaCare and which rules I must follow to get those benefits. I understand that services requiring an authorization will be denied if no authorization information is received from the doctor. I understand that I have the right to appeal decisions about payments and services if I disagree with SummaCare. I understand that while I am a member of any SummaCare Secure HMO-POS plan, I must use SC*Secure* providers in order to get the higher level of coverage, but the copay for urgent care or emergency care or dialysis services will be the same in-network and out-of-network. If medically necessary, SummaCare provides refunds for all covered benefits, even if I get services out-of-network.

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

Release of Information: By joining this Medicare health plan, I acknowledge that SummaCare will release my information to Medicare and other plans or providers as is necessary for treatment, payment and health care operations. I also acknowledge that SummaCare 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 on this application means that I have read and understand the contents. If this application is signed by an authorized individual such as a Power of Attorney or Legal Guardian, I understand that SummaCare or Medicare may request a copy of those documents for their files.

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Your Signature:	Today's Date:			
•	-			
If you are the authorized representative and/or have Power of Attorney (POA), you must sign above and provide the following information along with your POA form:				
Name:				
Address:				
Phone Number: Relations	ship to Enrollee:			
Plan Representative Signature:	Date:			
Please KEEP the YELLOW COPY for your records				



Typically, you may enroll in a Medicare Advantage Plan during the annual enrollment period which is from October 15 through December 7, 2012. There are exceptions that 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 enrolling during the annual enrollment period between October 15 and December 7.
I am new to Medicare.
I have had Medicare prior to now, but am just turning age 65.
I recently moved or within the next month I will move outside of the service area for my current plan and into the
service area for SummaCare. I moved or will move on (insert date):
I was terminated from my prior Medicare plan for living outside of its service area for more than six months.
I was terminated on (insert date):
I was recently released from a correctional facility 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 a Long-Term Care Facility (for example, a nursing home or rehabilitation hospital).
I will move into the facility on (insert date):
I currently live in a Long-Term Care Facility.
I recently moved out of a Long-Term Care 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.
I was unable to enroll in a Medicare Drug Plan when I first became eligible for Medicare, because no plan was
available where I lived at that time (for example, I lived outside of the country or was incarcerated.) I first moved
into an area where I could sign up for a Medicare Drug Plan on (insert date):
My prior Medicare (Advantage or Prescription Drug) plan (not SummaCare) is ending its contract with Medicare
or Medicare is ending its contract with my old plan, so I need a new plan.
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 recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on
(insert date):
I used the Medicare Advantage Disenrollment Period (MADP) to disenroll from my Medicare plan between
January 1 and February 14.

\*If none of these statements apply to you or you have any questions about this form, please contact SummaCare Secure Sales for assistance at 330-996-8440 or (toll free) 888-464-8440. Persons with hearing impairments please call TTY at 800-750-0750. A representative will be available to speak with you from 8 a.m. to 8 p.m. seven days a week.