CCHP 健華人保計劃 東華醫院 Chinese Community Health Plan

MEDICARE ADVANTAGE ENROLLMENT REQUEST FORM

445 Grant Avenue, Suite 700, San Francisco, CA 94108 • Tel: (415) 955-8800 • Fax: (415) 955-8819 • www.cchphmo.com

Please contact CCHP at (415) 955-8800 if you need information in another language or format.

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Please select a plan:

- ☐ **CCHP Senior Program (HMO) - San Francisco** $30 per month
- ☐ **CCHP Senior Program (HMO) - San Mateo** $30 per month
- ☐ **CCHP Senior Select Program (HMO)*** $26.10 per month

** If you are eligible for this plan, Medicare will pay the monthly plan premium.*

OFFICE USE ONLY

Member ID: ____________

Effective Date: ____________

Last Name	First Name		Middle Initial
Date of Birth (MM/DD/YYYY) __ __ / __ __ / __ __ __ __	Sex ☐ M ☐ F	Home Phone Number ( )	Alternate Phone Number ( )

Permanent Resident Street Address (P.O. Box is not allowed)

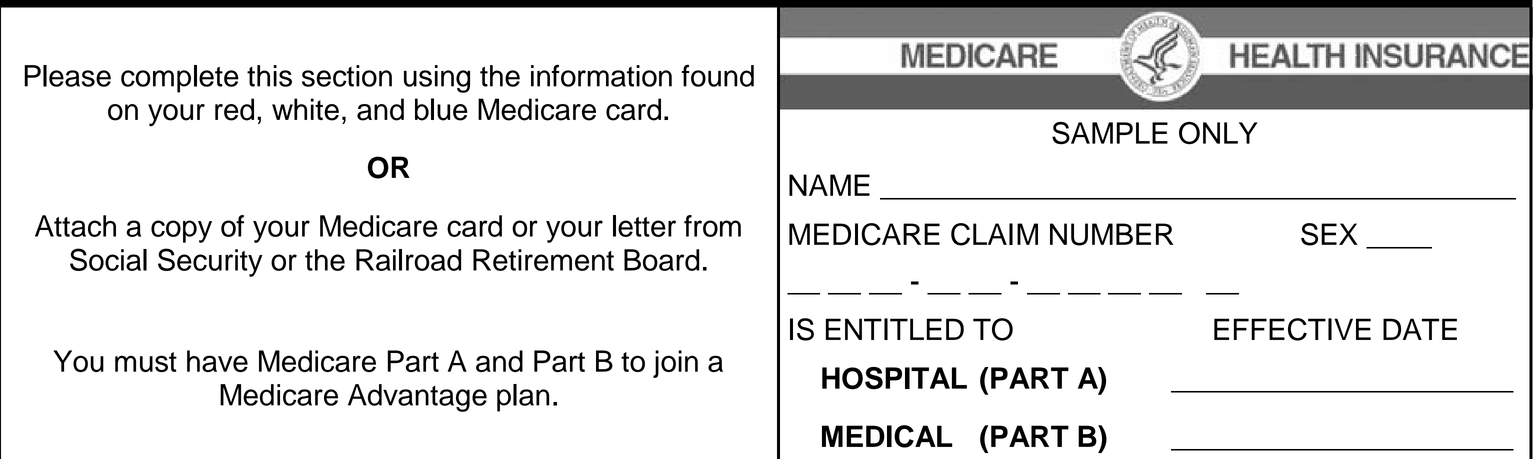
City	State	Zip Code

Mailing Address (Required only if different from Permanent Resident Address), City, State, & Zip Code

Emergency Contact	Phone Number ( )	Relationship to You

Email Address

YOUR MEDICARE HEALTH INSURANCE INFORMATION



Please complete this section using the information found on your red, white, and blue Medicare card.

OR

Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

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

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

NAME ______________________________

MEDICARE CLAIM NUMBER SEX ____

__ __ __ - __ __ - __ __ __ __ __

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL (PART A) ______________

MEDICAL (PART B) ______________

PAYING YOUR PLAN PREMIUM

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

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 doesn't cover.

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

Please select a premium payment option:

☐ Get a bill monthly.

☐ Electronic Funds Transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following information:

Account holder name: ________________________________ Account type: ☐ Checking ☐ Saving

Bank routing number: _______________________ Bank account number: ___________________________

☐ 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. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No

   If you answered 'Yes' to this question, but you no longer require regular dialysis, or if you had a successful kidney transplant, please attach a letter and records from your doctor.

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 this Plan? ☐ Yes ☐ No

   If 'Yes,' please list your other coverage and your identification (ID) number for this coverage:

   Name of other coverage: _______________________________________

   ID number for this coverage: __________________________ Group number: __________________________

3. Are you a resident of a long-term care facility, such as a nursing home? ☐ Yes ☐ No

   If 'Yes,' please provide the following information:

   Name of Institution: ____ Phone Number: __________________

   Street Address: ____________________________ City: ________________ State: ____ Zip Code: ________

4. Are you enrolled in Medi-Cal? ☐ Yes ☐ No

   If 'Yes,' please provide your Medi-Cal number: ____

5. Do you or your spouse work? ☐ Yes ☐ No

Please choose a Primary Care Physician (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:

☐ Chinese ☐ Large Print

If you need information in another language or format than what is listed above, please contact CCHP at 415-955-8800. TTY users should call 1-877-681-8898. Our office hours are 8:00 a.m. to 8:00 p.m., seven days a week.

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

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 don't add or drop your prescription drug coverage. If you have Medicare prescription drug coverage, you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage, you can only change to another plan without Medicare 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 or I recently moved and this Plan is a new option for me. I moved on (*insert date*) __ __ / __ __ / __ __ __ __.
- ☐ I have both Medicare and Medi-Cal 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, such as a nursing home. 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.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (*insert date*) __ __ / __ __ / __ __ __ __.
- ☐ None of these statements applies to me.*

* Please contact CCHP at 415-955-8800 (TTY users should call 1-877-681-8898) to see if you are eligible to enroll. We are open from 8:00 a.m. to 8:00 p.m., seven days a week.

PLEASE READ THIS IMPORTANT INFORMATION.

If you currently have health coverage from an employer or union, joining this Medicare health plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join this Medicare health plan. 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 isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

PLEASE READ AND SIGN BELOW.

Note: "Plan" refers to the Medicare health plan that you selected on page 1 of the enrollment request form.

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

This 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. 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.

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

Release of information: By joining this Medicare health plan, I acknowledge that CCHP will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that CCHP 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 by CCHP or by Medicare.

Signature: ____ **Date:** ____________

If you are the applicant's authorized representative, please sign above and complete the following information:

Name: ____

Address: ____

Phone Number: ______________________ Relationship to applicant: ______________________

OFFICE USE ONLY

Name of staff member (if assisted in enrollment): ____________________________ Date: ___________

PBP ID: ☐ 001 ☐ 005 ☐ 006

Group ID: SP650000 Subgroup ID: __ __ __ __

Election Period: ☐ ICEP ☐ IEP ☐ AEP ☐ OEP ☐ SEP

SEP Type: ☐ U - Dual Eligible/LIS ☐ W - EGHP
☐ V - Permanent Move ☐ S - Other: ______________

RECEIVED DATE STAMP

H0571_2010_13, CMS Approval (10/23/2009)

CCHP

MEDICARE QUESTIONNAIRE FOR BENEFICIARIES WITH PRESCRIPTION DRUG COVERAGE

NAME	DATE OF BIRTH	MEDICARE NUMBER

SECTION A - INFORMATION ABOUT YOU

1) Are **YOU** currently employed? **YES** ☐ **NO** ☐ (If **NO**, go to **SECTION B**)

2) Do **YOU** have any group health plan coverage through your current employer?
YES ☐ **NO** ☐ (If **NO**, go to **SECTION B**)

3) How many employees, including yourself, work for your employer?
Don't know ☐ **1-19** ☐ **20-99** ☐ **100 or more** ☐

Please provide information about the employer and the employer group health plan in the spaces below:

EMPLOYER NAME

ADDRESS

ADDRESS

CITY STATE ZIP

NAME OF GROUP HEALTH PLAN

ADDRESS

ADDRESS

CITY STATE ZIP

GROUP IDENTIFICATION NUMBER

DATE INSURANCE COVERAGE BEGAN POLICY NUMBER

M M — D D — Y Y Y Y

4) Does your employer group health plan cover prescription drugs? **YES** ☐ **NO** ☐ (If **NO**, go to **SECTION B**)
Please use your insurance card to provide the following information if available:

Rx GROUP Rx PCN

MEMBER ID Rx BIN

SECTION B - INFORMATION ABOUT YOUR HUSBAND/WIFE/FAMILY MEMBER

1) Is your family member currently employed? **YES** ☐ **NO** ☐ **N/A** ☐ (If **NO** or **N/A**, go to **SECTION C**)

Husband/Wife/Family Member's Name

First

Last

Husband/Wife/Family Member's Social Security Number

2) Does your husband/wife/family member have group health insurance coverage through their employer?
YES ☐ **NO** ☐ (If **NO**, **STOP**, go to **SECTION C**)

3) How many employees including your family member, work for the employer from whom they have health insurance?
Don't know ☐ **1-19** ☐ **20-99** ☐ **100 or more** ☐ (if **less than 20**, **STOP**, go to **SECTION C**)

SECTION B - INFORMATION ABOUT YOUR HUSBAND/WIFE/FAMILY MEMBER, CONTINUED

4) Does your husband/wife/family member's employer group health plan cover prescription drugs?

YES ☐ **NO** ☐ (If **NO**, go to **SECTION C**)

Please use your husband/wife/family member's insurance card to provide the following information if available:

RxGROUP

RxPCN

MEMBER ID

RxBIN

Please provide information about the employer and the employer group health plan in the spaces below:

EMPLOYER NAME

ADDRESS

ADDRESS

CITY

STATE

ZIP

NAME OF GROUP HEALTH PLAN

ADDRESS

ADDRESS

CITY

STATE

ZIP

GROUP IDENTIFICATION NUMBER

DATE INSURANCE COVERAGE BEGAN

M M — D D — Y Y Y Y

POLICY NUMBER

SECTION C - INFORMATION ABOUT YOUR SUPPLEMENTAL COVERAGE

1) Do you have any supplemental prescription drug coverage under your policy or another family member?

YES ☐ **NO** ☐ (If **NO**, go to **SECTION D**)

If **YES**, what is your relationship to the policy holder? ☐ Self ☐ Family Member ☐ Both

2) What type of policy is your supplemental drug coverage?

☐ TRICARE ☐ MEDIGAP ☐ State Pharmaceutical Assistance Program (SPAP) ☐ OTHER

Please print below the name, and address of the insurance company providing your prescription drug coverage:

NAME

ADDRESS

ADDRESS

CITY

STATE

ZIP

POLICY NUMBER

DATE COVERAGE BEGAN

M M — D D — Y Y Y Y

Please use your insurance card to provide the following information if available:

RxGROUP

RxPCN

MEMBER ID

RxBIN

(CONTINUED ON NEXT PAGE)

SECTION D - MORE INFORMATION ABOUT YOU

1) Are **YOU** receiving **Black Lung** Benefits? **YES** ☐ **NO** ☐
2) Are **YOU** receiving **Workers' Compensation** benefits? **YES** ☐ **NO** ☐
3) Are **YOU** receiving treatment for an injury or illness which another party could be held liable or could be covered under no-fault or auto insurance? **YES** ☐ **NO** ☐

STOP If **YOU** answered **YES** to any questions in this section, go to **SECTION E**
If **YOU** answered **NO** to all of these questions, sign below and return this form.

Your Signature

AREA CODE **PHONE NUMBER**

SECTION E - MORE INFORMATION ABOUT YOUR BENEFITS

1) If **YOU** are getting **Black Lung** (Coal Miner's) Medical Benefits, print the date the benefits began.

M M – D D – Y Y Y Y

2) If **YOU** are now receiving any medical services related to an illness or injury which occured on the job, for which **YOU** have or will file a **Workers' Compensation** claim, print the date the illness or injury.

M M – D D – Y Y Y Y

Please provide information about the employer, insurance carrier, and attorney in the spaces below:

EMPLOYER NAME

ADDRESS

ADDRESS

CITY STATE ZIP

NAME OF INSURANCE CARRIER

ADDRESS

ADDRESS

CITY STATE ZIP

POLICY or CLAIM NUMBER

NAME OF ATTORNEY (If Applicable)

ADDRESS

ADDRESS

CITY STATE ZIP

BRIEF DESCRIPTION OF ILLNESS OR INJURY

(TURN PAGE OVER)

SECTION E - MORE INFORMATION ABOUT YOUR BENEFITS, CONTINUED

3) If **YOU** are now getting any treatment for an illness or injury for which another party could be held liable, please print the date of illness or injury: ___ ___ — ___ ___ — ___ ___ ___ ___
M M D D Y Y Y Y

NAME OF INSURANCE CARRIER

ADDRESS

ADDRESS

CITY STATE ZIP

POLICY or CLAIM NUMBER

NAME OF ATTORNEY (If Applicable)

ADDRESS

ADDRESS

CITY STATE ZIP

BRIEF DESCRIPTION OF ILLNESS OR INJURY

4) If **YOU** are now getting any treatment for an illness or injury which could be covered under **no-fault** or **automobile insurance**, print the date the of illness or injury: ___ ___ — ___ ___ — ___ ___ ___ ___
M M D D Y Y Y Y

NAME OF INSURANCE CARRIER

ADDRESS

ADDRESS

CITY STATE ZIP

POLICY or CLAIM NUMBER

NAME OF ATTORNEY (If Applicable)

ADDRESS

ADDRESS

CITY STATE ZIP

BRIEF DESCRIPTION OF ILLNESS OR INJURY

Your Signature

AREA CODE — PHONE NUMBER