



EASY CHOICE MEDICARE ADVANTAGE PLANS INDIVIDUAL ENROLLMENT FORM

How to Enroll with Easy Choice

- 1 Please read this entire enrollment form to make sure you understand the information.
- 2 When you're ready, fill out the entire enrollment form. Where appropriate, write clearly in all capital letters or place an "X" in the appropriate box.
- 3 Once you're done, don't forget to sign and date it.
- 4 Return the completed/signed form to Easy Choice using the attached postage-paid business reply envelope.
- 5 Contact your Sales Agent with any questions you may have.

Sales Agent: _____ Phone: (____) ____ - _____

3 Other Easy Ways to Enroll with Easy Choice



Call Easy Choice Customer Service at **1-866-999-3945**.
TTY users should call **1-800-735-2929**.
Hours of operation are Monday–Friday, 8 a.m. to 8 p.m.
Between October 1 and February 14, representatives are available Monday–Sunday, 8 a.m. to 8 p.m., or visit us anytime at www.easychoicehealthplan.com.



Enroll online at www.easychoicehealthplan.com.



Enroll online at www.medicare.gov.



This information is available for free in other languages. Please call our Customer Service number at 1-866-999-3945, Monday–Friday, 8 a.m. to 8 p.m. Between October 1 and February 14, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. TTY users should call 1-800-735-2929.

Esta información está disponible gratis en otros idiomas. Por favor llame a nuestro número de Servicio al Cliente al 1-866-999-3945, de lunes a viernes, de 8 a.m. a 8 p.m. Entre el 1 de octubre y el 14 de febrero, los representantes están disponibles de lunes a domingo de 8 a.m. a 8 p.m. Los usuarios de TTY deben llamar al 1-800-735-2929.

本資訊免費提供其它語言版本。請撥打 1-866-999-3945 與我們的客戶服務部聯繫，服務時間為週一至週五，上午 8 點至晚上 8 點。在十月 1 日至二月 14 日之間，代表的服務時間為週一至週日，上午 8 點至晚上 8 點。TTY 用戶請撥打 1-800-735-2929。

이 정보는 다른 언어로 무료로 제공됩니다. 10월 1일부터 2월 14일까지 고객 서비스 전화번호 1-866-999-3945번으로 월요일부터 금요일까지, 오전 8시에서 오후 8시 사이에 전화하면 담당자와 통화하실 수 있습니다. TTY 사용자들은 1-800-735-2929 번에 월요일부터 금요일까지, 오전 8시에서 오후 8시 사이에 전화하십시오.

Thông tin này hiện có miễn phí bằng các ngôn ngữ khác. Xin gọi Dịch Vụ Khách Hàng của chúng tôi tại số 1-866-999-3945, Thứ Hai–Thứ Sáu, 8 sáng tới 8 tối Trong khoảng Ngày 1 Tháng Mười và 14 Tháng Hai, các đại diện có sẵn Thứ Hai–Chủ Nhật, 8 sáng tới 8 tối những người sử dụng TTY nên gọi số 1-800-735-2929.

Paying Your Plan Premium

If enrolling in a health plan with a \$0 monthly premium: 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. You can pay by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month, if eligible. 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 Easy Choice the Part D-IRMAA.

If enrolling in a plan with a monthly premium: You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month, if eligible. 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 Easy Choice the Part D-IRMAA.

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 do not 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 monthly bill to pay your premiums.

Please select a premium payment option:

Get a bill monthly Social Security Railroad Retirement Board

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check (if eligible). The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, or approves deductions to begin after the enrollment effective date, we will send you a bill for your monthly premiums.

Consent to Contact by Phone

Consent for non-telemarketing calls: I agree to receive non-telemarketing calls or text messages from the health plan using an automated phone dialing system that provides relevant, timely information regarding your health care and coverage. These calls may be pre-recorded. I may opt out at any time by calling the number on the back of my ID card. I understand that giving my consent to get calls or texts is not a condition to get the plan's products or services.

Yes (Agree to Consent) No (Do not Consent) Signature: _____

Consent for telemarketing calls: I agree to receive phone calls or text messages from the health plan on my cell phone using an automated phone dialing system or an artificial pre-recorded voice. These calls will provide information about our services, including marketing information and tips to help you make health care decisions. These calls or texts will go to the numbers provided on this application. I may opt out at any time by calling the number on the back of my ID card. I understand that giving my consent to get calls or texts is not a condition to get the plan's products or services.

Yes (Agree to Consent) No (Do not Consent) Signature: _____

Please Read and Answer These Important Questions:

1. Do you have end-stage renal disease (ESRD)? Yes No

If you have had a successful kidney transplant and/or you do not need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you do not need dialysis; otherwise, we may need to contact you to obtain additional information.

2. For MAPD Plans: 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 Easy Choice? 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 of 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 of Institution:

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 select ONE box for the language in which you prefer to receive information:

English Spanish (where available) Chinese (where available) Korean (where available) Vietnamese (where available)

Please select the box if you prefer to receive information in large print:

Please contact Easy Choice at the Customer Service number listed on the front cover of this booklet regarding the availability of information in a format or language other than what is listed above.

Please choose a primary care physician (PCP), clinic or health center: (First and Last Name of PCP)

ID#

Are you a current patient? Yes No

White: Office Copy Yellow: Member Copy

Emergency Contact Information:

Emergency Contact: (optional)

Phone Number: (optional) Relationship to You: (optional)

Sales Agent/Office Use Only:

Name of Staff Member/Agent/Broker (if assisted in enrollment):

Agent Signature: _____ Date Application Received:
M M D D Y Y Y Y

Agent Initials: Agent ID:

Agent Phone #:

Plan ID #: H Effective Date of Coverage:
M M D D Y Y Y Y

ICEP/IEP AEP SEP (type): Not Eligible Cancel Application

(White: Office Copy Yellow: Member Copy)

MC0609_68053CCP



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL

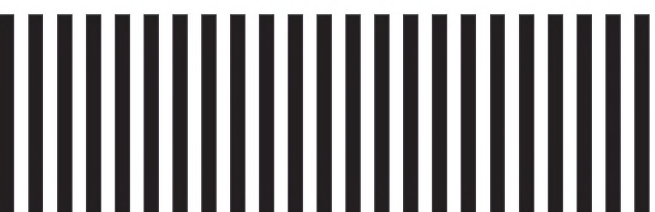
FIRST-CLASS MAIL

PERMIT NO. 9074

TAMPA, FL

POSTAGE WILL BE PAID BY ADDRESSEE

EASY CHOICE HEALTH PLAN
PO BOX 6025
CYPRESS CA 90630-9812



Remember to ...

- Fill out your application
- Return your completed application in this postage-paid envelope

請記得

- 填妥申請表
- 用隨附的郵資已付信封寄回填妥的申請表

잊지 마세요 ...

- 귀하의 지원서 작성하기
- 우표값이 미리 지불된 이 봉투에 작성한 지원서를 넣어 우편으로 보내기

Xin nhớ ...

- Điền đơn
- Dùng phong bì đính kèm và gửi trở lại lá đơn quý vị đã điền

Recuerde ...

- Complete su solicitud
- Envíe su solicitud diligenciada en este sobre con porte postal pago