EASY CHOICE MEDICARE ADVANTAGE PLANS

2017 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 at **P.O. Box 6025, Cypress, CA 90630** or by fax to **1-877-999-3945**.
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 **1-877-247-6272**. 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**.

Easy Choice HEALTH PLAN®
A WellCare Company

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-866-999-3945** (TTY: **1-877-247-6272**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-999-3945** (TTY: **1-877-247-6272**).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-866-999-3945** (TTY: **1-877-247-6272**)。

LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ trợ giúp ngôn ngữ miễn phí cho quý vị. Hãy gọi **1-866-999-3945** (TTY: **1-877-247-6272**).

주의: 를 사용하신다면 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-866-999-3945** (TTY: **1-877-247-6272**) 번으로 전화 주십시오.

2017 EASY CHOICE MEDICARE ADVANTAGE PLANS INDIVIDUAL ENROLLMENT FORM

Please contact Easy Choice if you need information in another language or format (Braille).

To Enroll in an Easy Choice Plan, Please Provide the Following Information:

Please select the box for the plan you want to enroll in:

☐001: Easy Choice Freedom Plan (HMO SNP) - Los Angeles
☐002: Easy Choice Plus Plan (HMO) - Orange, Riverside, San Bernardino
☐005: Easy Choice Best Plan (HMO) - Los Angeles, Orange
☐016: Easy Choice Best Plan (HMO) - Riverside, San Bernardino
☐017: Easy Choice Plus Plan (HMO) - Los Angeles

$ ☐☐☐.☐☐ per month

☐ Mr. ☐ Mrs. ☐ Ms. Sex: ☐ M ☐ F Birth Date: ☐☐☐☐☐☐☐☐ (M M D D Y Y Y Y)

Last Name:

Middle Initial: First Name:

Home Phone Number: Alternate Phone Number:

Email Address (optional):

Please know that by providing your email address, you are agreeing to receive emails from us. We will give you the opportunity to opt in and you may always opt out of future email communications.

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

County:

City: State: ZIP Code:

Mailing Address: (only if different from your Permanent Residence Street Address)

Street Address:

City: State: ZIP Code:

(White: Office Copy Yellow: Member Copy)

Please Provide Your Medicare Insurance Information:

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match 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: (MMDDYYYY)

HOSPITAL (Part A)

MEDICAL (Part B)

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:_____

(White: Office Copy Yellow: Member Copy)

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

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STOP Please Read This Important Information:

For MAPD Plans: If you currently have health coverage from an employer or union, joining an Easy Choice plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join an Easy Choice 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:

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

Easy Choice Health Plan (HMO), a WellCare company, is a Medicare Advantage organization with a Medicare contract. Enrollment in Easy Choice (HMO) depends on contract renewal. 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: October 15–December 7 of every year) or under certain special circumstances.

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

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

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Signature: _____ Today's Date: | | | | | | | | |
M M D D Y Y Y Y

If you are the authorized representative, you must sign above and provide the following information.

Would you like all mail to be sent to the authorized representative? ☐ Yes ☐ No

Name:

Address:

City: State: ZIP:

Phone Number: Relationship to Enrollee:

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and select the box if the statement applies to you. By filling in 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.

If the statement you select requires a date, please use the following format: MMDDYYYY

☐ I am a new Medicare beneficiary.

☐ 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 ☐☐☐☐☐☐☐☐.

☐ I recently was released from incarceration. I was released on ☐☐☐☐☐☐☐☐.

☐ I recently returned to the United States after living permanently outside of the U.S.
I returned to the U.S. on ☐☐☐☐☐☐☐☐.

☐ I recently obtained lawful presence status in the United States. I got this status on ☐☐☐☐☐☐☐☐.

☐ 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 ☐☐☐☐☐☐☐☐.

☐ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home).
I moved/will move into/out of the facility on ☐☐☐☐☐☐☐☐.

☐ I recently left a PACE program on ☐☐☐☐☐☐☐☐.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
I lost my drug coverage on ☐☐☐☐☐☐☐☐.

☐ I am leaving employer or union coverage on ☐☐☐☐☐☐☐☐.

☐ I belong to a pharmacy assistance program provided by my state or I am losing/recently lost participation in such a program on ☐☐☐☐☐☐☐☐.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my 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 ☐☐☐☐☐☐☐☐.

If none of these statements applies to you or you're not sure, please contact Easy Choice at 1-866-999-3945 to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., 7 days a week. TTY users should call 1-877-247-6272.

(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)

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