IMPERIAL HEALTH PLAN OF CALIFORNIA

Enrollment Application

Please contact Imperial Health Plan of California (HMO) and (HMO SNP) if you need information in another language or format (braille).

To enroll in Imperial Health Plan (HMO) (HMO SNP), please provide the following information: (please print)

Please check which plan you want to enroll in:

- ❑ 005 Senior Value (HMO SNP) $0 per month.
- ❑ 007 Imperial Traditional (HMO) $0 per month.
- ❑ 009 Imperial Traditional Plus (HMO) $34.80 per month.

LAST NAME:	FIRST NAME:	Middle Initial:
❑ Mr. ❑ Mrs. ❑ Ms. ❑ M ❑ F	Email Address: (optional)	

Home Telephone Number	Birth Date: (MM/DD/YY)	Alternate Phone Number: (optional)

Permanent Residence Street Address (P.O. Box is not allowed):	City:	State:	Zip Code
Mailing Address (If different from above):	City:	State:	Zip Code

Emergency contact:	Telephone Number:	Relationship to you:

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.

  - OR -

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

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

Is Entitled to: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

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

Paying Your Plan Premium:

For plans with no premium (plans 005, and 007): 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 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 the RRB. DO NOT pay Imperial Health Plan the Part D -IRMAA.

For plans with premium (plan 009): You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) 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 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 Imperial Health Plan 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 co-insurance. 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 monthly bill

❑ Automatic deductions from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ❑ Social Security ❑ RRB

(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, we will send you a paper bill for your monthly premiums.)

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 don't need regular dialysis any more, ***please attach a note or records*** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State pharmaceuticals assistance programs.
   Will you have other prescription drug coverage in addition to Imperial Health Plan?..... ❑ 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,
   Name of Institution: _____
   Address & Phone Number of Institution (number and street):
   _____

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

6. Do you have Cardiovascular Disorder, Chronic Heart Failure and/or Diabetes? ..... ❑ Yes ❑ No

Please choose the name of a Primary Care Physician (PCP) and Physician Group:

PCP First Name:	M.I.:	Last
Physician Group (spell out completely):		PCP ID#:

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an *accessible* format:

❑ Spanish ❑ Chinese Other: _____

❑ Braille ❑ Audio Tape ❑ Large Print

Please contact Imperial Health Plan at 800-838-8271 if you need information in an *accessible* format or language *other* than what is listed above. Our office hours are Monday through Sunday 8:00 am to 8:00 pm except holidays during October 1 through March 31 and Monday through Friday 8:00 am to 8:00 pm April 1 through September 30 except holidays.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Imperial Health Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Imperial 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

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

Imperial Health 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. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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.

Imperial Health Plan serves a specific service area. If I move out of the area that Imperial Health 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 Imperial Health Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Imperial Health Plan when I get 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 not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Imperial Health Plan coverage begins, I must get all of my health care from Imperial Health Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Imperial Health Plan and other services contained in my Imperial Health Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR IMPERIAL HEALTH 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 Imperial Health Plan, he/she may be paid based on my enrollment in Imperial Health Plan.

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

Signature:	**Today's Date:**

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

Name: _____ **Phone Number:** _____

Address: _____ **Relationship to Enrollee:** _____

Office Use Only

Name of Agent (if assisted in enrollment): _____

Plan ID#: _____

Effective Date of Coverage: _____

❑ ICEP/IEP ❑ AEP ❑ SEP (TYPE) ❑ Not eligible

Imperial Health Plan is an (HMO) (HMO SNP) with a Medicare Contract. Enrollment in Imperial Health Plan depends on contract renewal. Imperial Health Plan of California (HMO) (HMO SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-838-8271 (TTY: 711). ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-838-8271 (TTY: 711). 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 1-800-838-8271 (TTY: 711).