

Sandia Group Medicare Advantage Plan Enrollment Form

To Enroll, Please Provide the Following Information:

Senior Advantage Health Plan Choices (Choose One):

Lovelace Senior Plan

Presbyterian MediCare PPO

Name of Employer: Sandia National Laboratories

Enrollment Effective Date:

Last Name:

First Name:

Middle Initial

Date of Birth:

Gender: M F

Home Phone:

Cell:

E-Mail Address:

Permanent Residence Address:

City:

State:

Zip Code:

County:

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

City:

State:

Zip Code:

County:

Emergency Contact:

Phone Number:

Relationship to You:

E-mail address:

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 the Social Security Administration 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)	_____
HOSPITAL (Part B)	_____

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Please read and answer these important questions:

1. Are you the retiree? Yes No If yes, retirement date (month/date/year):

If no, Name of retiree:

2. Are you a surviving spouse? Yes No If yes, Name of spouse:

3. Are you covering a spouse or dependent(s) under this employer or union plan?

Yes No If "yes", name of spouse:

Name of dependent(s):

4. A.) Do you have End Stage Renal Disease (ESRD)? Yes No

If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant.

B.) Diagnosis Date (MM/DD/YYYY) ____/____/____

C.) Transplant Date (MM/DD/YYYY) ____/____/____

5. Some individuals may have other drug coverage, including other private insurance, TRI-CARE, Federal employee health benefits coverage, Worker's Compensation, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to the selected Senior Advantage 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:

6. Do you or your spouse work? Yes No If "yes", provide the following information:

Employer Name:

Employer Address:

Policy Holder Name:

Policy Number:

7. Are you a resident in a long-term care facility, such as a nursing home? Yes No

Date of Admission (MM/DD/YYYY) ____/____/____

If "yes" please provide the following information:

Name of Institution:

Address & Phone Number of Institution (number and street):

8. Are you enrolled in your state-subsidized medical plan? Yes No

Please provide your Medicaid number:

9. If you are enrolling in the **Lovelace Senior Plan** please choose the name of a primary Care Physician (PCP):

New

Established

Por Favor verifique la siguiente caja si usted prefiere que nosotros les enviemos la información en español:

If you need information in another format or language than what is listed above and have selected:

Presbyterian MediCare PPO please call (505)923-6060 or 1-800-797-5343, Monday through Sunday from 8 a.m. to 8 p.m. TTY users should call 1-888-625-8818.

Lovelace Senior Plan please call (505) 727-5400 or 1-800-808-7363 TTY 711

If you currently have health coverage from an employer or union, joining your selected Advantage Plan could affect your employer or union health benefits. If you have health coverage from an employer or union, joining an Advantage Plan may change how your current coverage works. 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 is no information on whom to contact, your benefits administrator or the office that answers about your coverage can help.

Please Read and Sign Below:

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

1. I will read the selected (Lovelace Senior Plan or Presbyterian MediCare PPO) *Member Handbook/Evidence of Coverage* when I receive it to know which rules I must follow in order to receive coverage in this Medicare Advantage plan.
2. I understand that the plan I have selected is a Medicare Advantage plan and I must maintain my enrollment in Medicare Part A and Part B insurance.
3. I can be in only one Medicare Advantage plan or Medicare Advantage Prescription Drug Plan at a time. By enrolling in a Medicare Advantage plan, I will automatically be disenrolled from any other Medicare Advantage plan or Prescription Drug Plan in which I am currently a member.

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4. It is my responsibility to inform the plan of any prescription drug coverage that I have or may get in the future.

5. I understand that if I do not 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.

6. I understand that I must enroll in the service area for which I reside in accordance to the Medicare Advantage Plan I have selected. Further, I understand that it is my obligation to notify the plan if I move or leave the service area so I can disenroll and find a new plan in my area.

a. Presbyterian MediCare PPO serves a specific service area.

b. Notify The Lovelace Senior Plan if you move outside the State of New Mexico

7. Enrollment in the selected plan is generally for the entire year.

8. I may leave this plan only at certain times of the year, or under certain special circumstances by sending a request to the selected Advantage Plan or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**, 24 hours a day, 7 days a week.

9. I understand that starting on the effective date of my coverage, I must receive all of my medical care from my selected Medicare Advantage Plan, except for emergency care, out-of area urgent care, dialysis care while temporarily outside the service area, or authorized referrals. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border (for example in Canada and Mexico). Services authorized by Lovelace Senior Plan or Presbyterian Medicare PPO, and other services contained in my Member Handbook/Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR SELECTED ADVANTAGE PLAN WILL PAY FOR THE SERVICES.**

Note: Lovelace Senior Plan and Presbyterian MediCare PPO cover emergency and urgent care worldwide.

10. I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Presbyterian MediCare PPO, he/she may be compensated based on my enrollment in Presbyterian MediCare PPO.

11. Once I become a member of the selected plan, I have the right to appeal plan decisions about payment or services.

Release Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge the selected 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 behalf of the individual under the laws of the State where the individual resides) 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 your selected Medicare Advantage Plan or by Medicare.

Your Signature:

Today's Date:

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

Name:

Address:

Phone Number:

Relationship to Enrollee:

IMPORTANT: You must mail this form with the Open Enrollment Change Form 2010 postmarked by November 10, 2009.

INTERNAL USE ONLY

Move SEP **LIS SEP** **Institutionalized SEP** **EGHP SEP**