

UPMC *for Life*

UPMC Health Plan Medicare Program

If you have questions about this form, please call us at 1-877-381-3765. TTY users should call 1-800-361-2629.

OFFICE USE ONLY			
Plan ID#:	Effective Date:		
ICEP/IEP:	AEP:	SEP (type):	Not Eligible:
Plan Representative/Broker:			
If you assisted with this application, sign and date here:			
Application Mailed: _____		Faxed: _____	

Please contact UPMC for Life if you need information in another language or format (e.g., Braille).

I. TO ENROLL IN UPMC <i>for Life</i> , PLEASE PROVIDE THE FOLLOWING INFORMATION			
Name: First	M.I.	Last	Home phone number: ()
Date of birth: mm/dd/yyyy	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Alternate phone number (optional): ()
Email address (<i>optional</i>) and indicate permission to send information via email (e.g., newsletter): <input type="checkbox"/> Yes <input type="checkbox"/> No			
Permanent residence address (Street, Apartment #): <i>P.O. Box is not allowed.</i>			
City:	State:	Zip code:	County:
Mailing address (Street, Apartment #): <i>Only complete if different from permanent residence address.</i>			
City:	State:	Zip code:	County:

2. PROVIDE YOUR MEDICARE INFORMATION
Please fill in the card to the right with the information from your red, white, and blue Medicare card. Otherwise, please attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. You must have Medicare Parts A and B to join our Plan. We cannot consider your enrollment complete until you have given us this information.

MEDICARE HEALTH INSURANCE	
Sample Only	
Name of beneficiary: _____	
Medicare claim number: _____	
Is entitled to:	Effective date:
<input type="checkbox"/> Hospital Insurance (Part A) _____	
<input type="checkbox"/> Medical Insurance (Part B) _____	

3. PLEASE CHECK WHICH UPMC <i>for Life</i> PLAN YOU WANT TO ENROLL IN
You must continue to pay your Medicare Part B premium, in addition to the UPMC <i>for Life</i> premium, if applicable. The plans and premiums listed below are for 2015 and may be different if you are enrolling for another year.
<input type="checkbox"/> UPMC <i>for Life</i> (HMO) - \$0 monthly premium – This HMO plan does not include prescription drug coverage.
<input type="checkbox"/> UPMC <i>for Life</i> HMO Deductible with Rx (HMO) - \$18.00 monthly premium
<input type="checkbox"/> UPMC <i>for Life</i> HMO Rx (HMO) - \$78.00 monthly premium
<input type="checkbox"/> UPMC <i>for Life</i> HMO Rx Enhanced (HMO) - \$223.00 monthly premium
<input type="checkbox"/> UPMC <i>for Life</i> PPO High Deductible with Rx (PPO) - \$39.00 monthly premium
<input type="checkbox"/> UPMC <i>for Life</i> PPO Rx Enhanced (PPO) - \$139.00 monthly premium

4. SELECT A PRIMARY CARE PHYSICIAN (PCP) – HMO & PPO Plans (for in-network services)
Name of selected PCP: _____ Practice # (from provider directory): _____
Are you currently a patient of this physician? <input type="checkbox"/> Yes <input type="checkbox"/> No

5. SELECT A UPMC *for Life* PREMIUM PAYMENT OPTION

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe), by check, Electronic Funds Transfer (EFT), or credit card 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.

I would like to pay my monthly plan premium, if applicable, by:

- Paper Check EFT Credit Card

If you elected to pay your premium by credit card or EFT you will receive additional information about electronic premium payment options with your UPMC *for Life* plan confirmation of enrollment letter.

Automatic deduction from my monthly Social Security or Railroad Retirement Board (RRB) benefit check.

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.

Late Enrollment Penalty: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we will include this amount on your monthly premium bill. You can also choose to pay your late enrollment penalty by automatic deduction from your Social Security or RRB benefit check each month.

Part D IRMAA: If you are assessed a Part D-Income Related Monthly Adjustment Amount (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 and/or late enrollment penalty. You can either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. **DO NOT pay UPMC *for Life* the Part D-IRMAA.**

Low Income Subsidy: 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 only pays a portion of your plan premium, we will bill you for the amount that Medicare doesn't cover.

6. OTHER HEALTH INSURANCE INFORMATION

1) Do you or your spouse work full time? Yes No
Are you receiving group health insurance through your or your spouse's employer? Yes No

2) Will you have other medical coverage in addition to UPMC *for Life*? Yes No
If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Insurance company name:	ID number:
Insurance company phone #:	Group number:
Subscriber name:	Subscriber date of birth:

3) Are you enrolled in your state Medicaid program? Yes No
If "yes," please provide your Medicaid number: _____

6. OTHER HEALTH INSURANCE INFORMATION (continued)

Some individuals may have other **drug coverage**, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or State Pharmaceutical Assistance Programs (e.g., PACE).

- 4) Will you have other prescription drug coverage in addition to UPMC *for Life*? Yes No
If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Insurance company name: _____

ID number: _____

Group number: _____

7. PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

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

You may be able to enroll in this plan, if you are currently enrolled in a UPMC Health Plan commercial product or if you have had a successful kidney transplant, and/or you no longer need regular dialysis. Please attach a note or records from your doctor. If this documentation is not attached, we may need to contact you to obtain additional information.

- (b) Are you a resident in a long-term care facility, such as a nursing home? Yes No

If "yes" please provide the following information (*this will NOT prevent you from enrolling in our plan*):

Name of institution: _____ Phone number of institution: _____

Address of institution: _____

8. INFORMATION TO DETERMINE YOUR 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 check all of the boxes to the left of the statements that apply to you.** By checking any of the 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.

<input type="checkbox"/> I am new to Medicare.	<input type="checkbox"/> I recently left a Program for All Inclusive Care for the Elderly program on (insert date) _____.
<input type="checkbox"/> I am either losing or leaving my employer or union group coverage on (insert date) _____.	<input type="checkbox"/> I get extra help paying for Medicare prescription drug coverage.
<input type="checkbox"/> 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) _____.	<input type="checkbox"/> I belong to a pharmacy assistance program provided by my state (e.g., PACE).
<input type="checkbox"/> I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.	<input type="checkbox"/> I recently left a pharmacy assistance program (e.g., PACE) on (insert date) _____.
<input type="checkbox"/> I am moving into, live in, or recently moved out of a long-term care facility (e.g., nursing home). I moved/will move into/out of the facility on (insert date) _____.	<input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
<input type="checkbox"/> I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.	<input type="checkbox"/> I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____.
<input type="checkbox"/> My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.	<input type="checkbox"/> I was enrolled in a Special Needs Plan (SNP) but I have lost the required special needs qualification. I was disenrolled from the SNP on (insert date) _____.
<input type="checkbox"/> None of these statements apply to me.	

8. INFORMATION TO DETERMINE YOUR ENROLLMENT PERIOD (continued)

Due to statements checked in this section, if it is determined that more than one effective date is applicable, my preferred effective date of enrollment is (insert date) _____.

9. ALTERNATIVE FORMAT OPTIONS

If you require information in an alternative format, please check one of the boxes below or contact UPMC *for Life* at the phone number provided on page 1 of this application.

Audio Large print Braille Language (please list) _____

Release of Information: By joining this Medicare Advantage health plan, I acknowledge that UPMC *for Life* will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that UPMC *for Life* will release my information, including my prescription drug event data (if applicable), to Medicare, which may release it for research and other purposes that 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. **Your signature on this application means that you have reviewed and understand the plan benefits/premium and Rights and Responsibilities listed at the BEGINNING of this form.**

I completed this application with assistance from a UPMC Health Plan representative.

Face-to-face meeting Telephone call Completed by myself

Signature: _____ Today's Date: _____

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

Name: _____ Relationship to enrollee: _____

Address: _____ Phone number: (_____) _____

Please return the **WHITE COPY** to UPMC *for Life* in the **postage-paid envelope** provided. **Please keep the Duplicate Copy for your records.**