WINhealth PARTNERS
Your partner for life.
Medicare Health Plan Offered Through Rocky Mountain Health Plans

Medicare Rx
Prescription Drug Coverage

PO Box 10600
Grand Junction, CO 81506

Application for WINhealth Partners Individual Medicare Plans

Please contact WINhealth Partners Medicare if you need information in another language or format (Braille).

— Please detach before completing form —

To enroll in WINhealth Partners Medicare, please provide the following information:

Please check which plan you want to enroll in:

❑ Green Plan + Rx (Cost) ❑ Thrifty Plan + Rx (Cost) ❑ Standard Plan + Rx (Cost)
❑ Green Plan (Cost) ❑ Thrifty Plan (Cost) ❑ Standard Plan (Cost)

Coverage begins on the 1st day of the month. What effective date are you applying for (mm/dd/yy)?____________________

LAST Name:	FIRST Name:	Middle Initial:	❑ Mr. ❑ Mrs. ❑ Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ❑ M ❑ F		Home Phone Number: ( )

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

City:	State:	Zip Code:

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

Street Address: City: State: ZIP Code:

Emergency contact (optional)**:** ____
Phone Number (optional)**:** **Relationship to You** (optional)**:**

E-mail Address (optional)**:**

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 B to join any of the plans listed above.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: ____

Sex_________

Medicare Claim Number

___ ___ ___ — ___ ___ — ___ ___ ___ ___ _____

Is Entitled To Effective Date

HOSPITAL (Part A) ______________________

MEDICAL (Part B) ______________________

Paying Your Plan Premium

You can pay your monthly plan premium by mail, Electronic Funds Transfer (EFT), or credit card. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, 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 won't have a 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 800-772-1213. TTY users should call 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 quarter.

Please select a premium payment option:

❑ Receive a bill (mailed to you quarterly)

❑ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: ____________________

Account holder signature: ____________________

Bank routing number: ____________________

Bank account number: ____________________

Account type: ❑ Checking ❑ Saving

❑ Credit Card (monthly payment). Please provide the following information:

Type of Card: ____________________

Name of Account holder as it appears on card: ____________________

Account holder signature: ____________________

Account number: ____________________

Expiration Date: ____ ____/__________ (MM/YYYY)

❑ Automatic deduction from your monthly *Social Security* benefit check. (The *Social Security* deduction may take two or more months to begin. In most cases, the first deduction from your *Social Security* benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? ❑ **Yes** ❑ **No**
   If you answered "yes" to this question and you don't need regular dialysis any more, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant.

2. 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 a WINhealth Partners Part D 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:

— Please detach before completing form —

3. Are you a resident in 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 (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

Do you have health coverage through you or your spouse's current or former employer? ❑ Yes ❑ No

If "yes," please provide the following information:

Employer Name: ____________________ Employer Address:____________________

Policy Holder Name: ____________________ Policy Number:____________________

Please choose the name of a Primary Care Physician (PCP), clinic or health center:

Physician and/or Clinic Name:____________________

Address:

Please Read This Important Information

If you currently have health coverage from an employer or union, joining WINhealth Partners Medicare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join an RMHP plan with Medicare prescription drug coverage. 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

<u>By completing this enrollment application, I agree to the following:</u>

WINhealth Partners is a Medicare plan with an optional supplemental Part D benefit, and has a contract with the Federal government. I understand that I am not required to choose the optional supplemental Part D benefit. I will need to keep my Medicare Parts A and B or B only. I can be in only one Medicare health plan or Part D drug 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 WINhealth Partners Medicare of any prescription drug coverage that I have or may get in the future. I understand that if I don't have or get other 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 in a plan that includes Part D, I may leave the plan or make changes only at certain times of the year when an enrollment period is available (Example: November 15 – December 31 of every year), or under certain special circumstances.

WINhealth Partners Medicare serves a specific service area. If I move out of the area that WINhealth Partners Medicare serves, I need to notify the plan so I can disenroll and find a new plan in my new area. If I enroll in a Part D plan, I understand that I must use network pharmacies except in an emergency when I cannot reasonably use WINhealth Partners Medicare network pharmacies.

Once I am a member of WINhealth Partners Medicare, I have the right to appeal plan decisions about payment or services if I disagree.

— Please detach before completing form —

I will read the Evidence of Coverage document from WINhealth Partners Medicare when I get it to know which rules I must follow in order to get coverage. I agree to abide by the terms and conditions set forth in the Evidence of Coverage. 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. Services authorized by WINhealth Partners Medicare and other services contained in my WINhealth Partners Medicare Evidence of Coverage document will be covered.

I understand that beginning on the date WINhealth Partners Medicare coverage starts, in order for WINhealth Partners Medicare to cover my medical services (except for emergency or urgently-needed services), my health care must be provided by WINhealth Partners plan providers or be authorized by WINhealth Partners. If I obtain services outside of the WINhealth Partners network that have not been authorized, I will be responsible for all Medicare deductibles and coinsurance, as well as any additional charges as prescribed by the Medicare program. I may also be liable for charges not covered by Medicare.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with WINhealth Partners Medicare, he/she may be paid based on my enrollment in WINhealth Partners Medicare.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

I understand that WINhealth Partners Medicare will send me written notification of the effective date of my enrollment.

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

I also acknowledge that WINhealth Partners Medicare 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 State law 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 by WINhealth Partners or by Medicare.

Signature:	**Today's Date:**

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

Name: ____________________

Address: ____________________

Phone Number: (_____) ____________________

Relationship to Enrollee:

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): ____________________

Plan ID#: ____________________

Effective Date of Coverage: ____________________

IEP:__________ AEP:__________ SEP (type):__________ Not Eligible:____________________

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Attestation of Eligibility for an Enrollment Period

(Please complete this form only if you are applying for Medicare Part D Prescription Drug Coverage).

You can enroll in certain WINhealth Partners Medicare plans at any time. Typically, however, you may enroll in a plan that offers Medicare prescription drug coverage only during the annual enrollment period between November 15 and December 31 of each year. Additionally, there are exceptions that may allow you to enroll in a plan with Medicare prescription drug coverage outside of the annual enrollment period.

Please read the following statements carefully and check the box if the statement applies to you. By checking 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.

- ☐ I am new to Medicare.
- ☐ 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) ________________.
- ☐ 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 drug coverage. I stopped receiving extra help on (insert date) ________________.
- ☐ I live in or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) ________________.
- ☐ I recently left a PACE program on (insert date) ________________.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) ________________.
- ☐ I am leaving employer or union coverage on (insert date) ________________.
- ☐ I belong to a pharmacy assistance program provided by my State.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date ________________.
- ☐ None of these statements applies to me*.

*Please call 800-949-6952 x 241 or 307-773-1300 x 241 to see if you are eligible to enroll. TTY users should call the Wyoming Relay Center at 800-877-9975.