Instructions for the Universal Medicare Advantage Form

This Medicare Advantage (previously called Medicare + Choice) Universal Enrollment Form is included with your UC Confirmation Statement because you or an eligible family member have recently enrolled in a California Medicare Advantage plan. In order to complete enrollment, the Medicare Advantage plan must receive this completed form before December 10, 2004.

Before you sign the form, please read the "Statement of Understanding" on the final page.

After you complete the form, keep the pink copy for your records and mail the remaining copies to your medical plan (see below). If you have recently completed and submitted a Medicare Advantage Enrollment form from your plan, you do not need to complete this form.

Health Net/Seniority Plus
P.O. Box 10198
Van Nuys, CA 91410

Kaiser Permanente—California/Senior Advantage
Attn: Medicare
P.O. Box 232400
San Diego, CA 92193-2400

PacifiCare of California/Secure Horizons
5701 Katella Ave.
Mail Stop CY24-120
Cypress, CA 90630

Western Health Advantage/WHA+
Attn: Medicare Dept.
1331 Garden Highway, Suite 100
Sacramento, CA 95833

If you enrolled in PacifiCare of Nevada/Secure Horizons, you cannot use this form. Please write PacifiCare of Nevada and request an enrollment packet that includes their Medicare Enrollment form (see below).

PacifiCare of Nevada/Secure Horizons
Desert Regional Service Center
Attn:Jesse Molina
700 Warm Springs Rd.
4601 E. Hilton Ave.
Phoenix, AZ 85034

1-800-347-8600

To be filled out by Employer
Group # ______
Account # ______
Effective Date ____ / ____ / ____

Medicare + Choice Universal Enrollment Form

Medicare + Choice plan you are requesting enrollment in:

Desired Contracting Medical Group	Desired Contracting Physician	Medical Group/Physician No.

Last Name	First Name	MI	Social Security No.

Permanent Residence Address	City	State	Zip
Mailing Address (if different)	City	State	Zip

Telephone Number (including area code)	Birth Date	Sex ☐ Male ☐ Female

Part A Effective Date	Part B Effective Date	Health Insurance Claim No. (HIC)

Are you currently a member of a Medicare + Choice plan?
☐ Yes ☐ No If so, which one?

Spouse	Name (Last, First, MI)		Birth Date	Sex ☐ Male ☐ Female
	Health Insurance Claim No.	Part A Effective	Part B Effective	Social Security No.
Dependent	Name (Last, First, MI)		Birth Date	Sex ☐ Male ☐ Female
	Health Insurance Claim No.	Part A Effective	Part B Effective	Social Security No.

For all family members enrolling in the Medicare + Choice product, please answer the following:	Subscriber	Spouse	Dependent
1. Do you have end-stage renal disease (ESRD)? ESRD is permanent kidney failure and requires you to have regular dialysis or a transplant to stay alive. If yes, date of diagnosis.	☐ Yes ☐ No __ /__ /__	☐ Yes ☐ No __ /__ /__	☐ Yes ☐ No __ /__ /__
2. Do you or your spouse currently work or plan to work for an employer who provides group health coverage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, workers' compensation, or Veterans Administration benefits?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, what is the name of your insurance?	______	______	______
4. Do you currently reside in an institution? Your answer to this question will not affect your eligibility to enroll.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please answer the following: Facility Name	______	______	______
Date of Admission	__ /__ /__	__ /__ /__	__ /__ /__
Facility Phone Number	( ) ______	( ) ______	( ) ______
5. Do you have Medi-Cal/Medicaid coverage? Your answer to this question will not affect your eligibility to enroll.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Responses to questions 1 - 5 above will not be used for health screening purposes.

I understand that my signature on this application certifies that I have read and understand the contents of this application and the Statement of Understanding on the reverse side of this form. Please refer to the Medicare + Choice plan Evidence of Coverage document for a written copy of the rules you must follow in order to receive coverage under this Medicare + Choice plan. Please keep the pink copy of this form for your records.

Subscriber Signature ______________________ Date ____________

Spouse Signature ______________________ Date ____________

If anyone helped the beneficiary fill out any portion of this form, with the exception of the effective date, please sign the following:

Representative Signature ______________________ Date ____________

Relationship to Beneficiary ______________________ Date ____________

If this is being submitted by a guardian, conservator, or person with power of attorney, please attach the legal documents establishing guardianship, conservatorship, or power of attorney.

To be filled out by Employer
Group # ______
Account # ______
Effective Date ___ / ___ / ___

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Mailing Address (if different)	City	State	Zip

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Part A Effective Date	Part B Effective Date	Health Insurance Claim No. (HIC)

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	Health Insurance Claim No.	Part A Effective	Part B Effective	Social Security No.
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	Health Insurance Claim No.	Part A Effective	Part B Effective	Social Security No.

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2. Do you or your spouse currently work or plan to work for an employer who provides group health coverage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, workers' compensation, or Veterans Administration benefits? If yes, what is the name of your insurance?	☐ Yes ☐ No ______	☐ Yes ☐ No ______	☐ Yes ☐ No ______
4. Do you currently reside in an institution? Your answer to this question will not affect your eligibility to enroll. If yes, please answer the following: Facility Name Date of Admission Facility Phone Number	☐ Yes ☐ No ______ __ /__ /__ ( ) ______	☐ Yes ☐ No ______ __ /__ /__ ( ) ______	☐ Yes ☐ No ______ __ /__ /__ ( ) ______
5. Do you have Medi-Cal/Medicaid coverage? Your answer to this question will not affect your eligibility to enroll.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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	Health Insurance Claim No.	Part A Effective	Part B Effective	Social Security No.
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2. Do you or your spouse currently work or plan to work for an employer who provides group health coverage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, workers' compensation, or Veterans Administration benefits?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, what is the name of your insurance?	______	______	______
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If yes, please answer the following: Facility Name	______	______	______
Date of Admission	__/__/__	__/__/__	__/__/__
Facility Phone Number	( ) ______	( ) ______	( ) ______
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Canary = Employer Group Benefits Administrator

To be filled out by Employer
Group # ______
Account # ______
Effective Date ___ / ___ / ___

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Last Name	First Name	MI	Social Security No.

Permanent Residence Address	City	State	Zip

Mailing Address (if different)	City	State	Zip

Telephone Number (including area code)	Birth Date	Sex ☐ Male ☐ Female

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2. Do you or your spouse currently work or plan to work for an employer who provides group health coverage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, workers' compensation, or Veterans Administration benefits? If yes, what is the name of your insurance?	☐ Yes ☐ No ______	☐ Yes ☐ No ______	☐ Yes ☐ No ______
4. Do you currently reside in an institution? Your answer to this question will not affect your eligibility to enroll. If yes, please answer the following: Facility Name Date of Admission Facility Phone Number	☐ Yes ☐ No ______ __ /__ /__ ( ) ______	☐ Yes ☐ No ______ __ /__ /__ ( ) ______	☐ Yes ☐ No ______ __ /__ /__ ( ) ______
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Representative Signature ______________________ Date __________

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Pink = Medicare Beneficiary

STATEMENT OF UNDERSTANDING

Please read each of the statements that follow before signing this form:

Lock-In: I understand that, beginning on the date my Medicare+Choice coverage begins, I must get all of my health care from the Medicare+Choice plan, with the exception of out-of-plan emergency and out-of-area urgently needed services or dialysis services. I understand that services authorized by the Medicare+Choice plan and other services contained in my Medicare+Choice plan Evidence of Coverage document will be covered. I also understand that, without authorization, neither Medicare nor the Medicare+Choice plan will pay for the services. As an M+C plan member, I understand that I am bound by the benefits, copayments, exclusions, limitations, and other terms of the Medicare+Choice plan Evidence of Coverage.

I understand that I will be notified by mail of the final confirmation of my enrollment in the plan and the effective date of my coverage. I understand that I should not disenroll from any supplemental plan until my enrollment is confirmed.

I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premium, and the Part A premium, if applicable.

I understand that I can be a member of only one Medicare+Choice plan at a time. By enrolling in the Medicare+Choice plan specified on this form, I understand that I will be automatically disenrolled from any other Medicare+Choice plan of which I am currently a member.

I also understand that since I can be a member of only one Medicare+Choice plan at a time, I cannot enroll in more than one Medicare+Choice plan with the same effective date of coverage. If I do this, my enrollments will be canceled and I will have to fill out a new enrollment form to become a member of a Medicare+Choice plan.

By enrolling in this Medicare+Choice plan, I authorize the Health Care Financing Administration (HCFA) to give information to the plan. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B). I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give HCFA or HCFA's agents the information needed to run the Medicare program.

I hereby authorize any person including, but not limited to, physicians, hospitals, insurance companies, and other organizations to release any information acquired by such person in the course of examination or treatment of myself, which is relevant to the provision of or coordination of benefits or the professional review activities.

I understand that I may request termination of this Medicare+Choice plan at any time by sending a written request for disenrollment to the health plan, the Social Security office, or the Railroad Retirement Board. Until the effective date of disenrollment, I must continue to receive health care from the plan providers.

I understand that it is my responsibility to inform the Medicare+Choice plan before permanently moving out of the service area or a continuation area, if applicable to your plan. I understand that if I move permanently out of the service area or continuation area, Medicare requires the Medicare+Choice plan to disenroll me.

I understand that if I disenroll from the employer-sponsored Medicare+Choice health plan, I will be automatically transferred to the Original Medicare plan (fee-for-service program). Also, I understand that if I choose to enroll in a non-employer-sponsored Medicare+Choice health plan, or another employer-sponsored Medicare+Choice plan, I will be automatically disenrolled from this employer-sponsored health plan.

I understand that, as a member of the Medicare+Choice plan, I have the right to appeal service and payment denials made by the plan.

Arbitration Agreement

All or most Medicare+Choice health plans require arbitration of disputes relating to or arising from the plans' membership agreement, including disputes over the denial of services, payment requests, or other benefits. Some of these health plans also require arbitration of claims, including medical or hospital malpractice and premises liability claims, that relate to or arise from a member's relationship with the hospitals, physicians, and other providers from whom members receive or seek health care services. Small Claims Court cases may be excluded from these arbitration requirements. The specific terms and conditions of a health plan's arbitration process are described in the plan's *Evidence of Coverage* booklet, which you should read before you choose to enroll in the plan. By enrolling in one of these health plans, you are agreeing to waive your right to a trial by jury or by a court, except as California law provides for judicial review of arbitration proceedings. You are also waiving the same rights of your dependents, heirs, or other claimants associated with you insofar as the health plan's arbitration provisions apply to them. Note that none of the health plan's arbitration provisions require arbitration of claims that are subject to Medicare's exclusive administrative appeal remedy.