Banner
University Health Plans
Banner – University Care Advantage

Individual Enrollment Request Form

Please contact Banner - University Care Advantage (HMO SNP) if you need information in another language or format (Braille)

To enroll in Banner - University Care Advantage, please check which plan you want to enroll in

- ☐ Banner - University Care Advantage (HMO SNP) H4931 001
- ☐ Banner - University Care Advantage (HMO SNP) H4931 006
- ☐ Banner - University Care Advantage (HMO SNP) H4931 007
- ☐ Banner - University Care Advantage (HMO SNP) H4931 008
- ☐ Banner - University Care Advantage (HMO SNP) H4931 013
- ☐ Banner - University Care Advantage (HMO SNP) H4931 014
- ☐ Banner - University Care Advantage (HMO SNP) H4931 015
- ☐ Banner - University Care Advantage (HMO SNP) H4931 016

LAST Name:	FIRST Name:	Middle Initial	Mr. Mrs. Ms. ☐ ☐ ☐

Birth Date: (MM/DD/YYYY)	Sex: ☐ F ☐ M	Home Phone #: (area code first)	Alternate Phone #:

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

City:	County:	State:	Zip:

Mailing Address ***(Only if different from your Permanent Residence Address):***

Street Address:

City:	State:	Zip:

Emergency Contact: .....

Phone #: ..... **Relationship:** .....

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 #: .....

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

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 Banner - University Care Advantage 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, con-tact 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 bill

☐ Automatic deduction from your 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.)

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 benefit coverage, VA benefit or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Banner - University Care Advantage? **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," please provide the following information:

Name of Institution: ..... **Phone:** .....

Address of Institution: .....

4. Are you enrolled in your State Medicaid program? ☐ **Yes** ☐ **No**

If yes, please provide your Medicaid number: .....

(continued on following page)

5. Do you or your spouse work? ☐ **Yes** ☐ **No**

6. Are you entitled to Medicare Part A? ☐ **Yes** ☐ **No**
Are you enrolled in Medicare Part B? ☐ **Yes** ☐ **No**
Do you live in the service area? ☐ **Yes** ☐ **No**

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

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** ☐ **Large Print**

Please contact Banner - University Care Advantage at (877) 874-3938 if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. - 8 p.m., 7 days a week. TTY users should dial 711.

STOP, Please Read This Important Information

If you currently have health coverage from an employer or union, joining Banner - University Care Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Banner - University Care Advantage. 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 benefit 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:
Banner - University Care Advantage 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. 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.

Banner - University Care Advantage serves a specific service area. If I move out of the area that Banner -University Care Advantage 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 Banner - University Care Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Banner - University Care Advantage 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 covered under Medicare while out of the country except for limited coverage near the U.S. border.

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

Release of Information: By joining this Medicare health plan, I acknowledge that Banner - University Care Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Banner - University Care Advantage 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 statues 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.

(continued on following page)

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: .....

Address .....

Phone Number: ..... **Relationship to Enrollee:** .....

Office Use Only

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

Plan ID #: H4931

Election period: ICEP/IEP:	AEP:	SEP (type):	OEP Only:

Selling Agent Name:	Selling Agent ID#:

Selling Agent Phone Number:

Referring Agent Name & ID:

Proposed Effective Date of Coverage:	Application Received Date:

Is benefit a current patient of PCP listed on page 3? ☐ **Yes** ☐ **No**

Coordination of Care: ☐ **Yes** ☐ **No**

Was the Scope of Appointment Form submitted? ☐ **Yes** ☐ **No**

If No, reason: ☐ **Sales Event** ☐ **Mail In** ☐ **Other:**

Selling Agent Signature: ..... Date: .....

Fax completed enrollment form to 1-855-231-9237

Banner – University Care Advantage is an HMO SNP with a Medicare contract. Enrollment in Banner – University Care Advantage depends on contract renewal.

Banner – University Care Advantage (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. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (877) 874-3930 (TTY: 711).