



Group Health Cooperative Medicare Advantage Election Form

Medicare Enrollment, PO Box 34255, Seattle, WA 98124-1255

1-888-901-4600; TTY, 1-800-833-6388 or 711

Personal information

Last name (as it appears on Medicare card)		First name (as it appears on Medicare card)			MI
Permanent residential address		City	County	State	ZIP
Mailing address (if different from above)		City	County	State	ZIP
E-mail		Telephone (primary)	Date you moved to residential address		
Birth date	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	Telephone (secondary)	Consumer number if applicable		

Medicare information

This information is on your red, white, and blue Medicare card. Please see back of page for example and more information.

Social Security #	Medicare claim #
Medicare Part A (hospital) effective date	Medicare Part B (medical) effective date

Medical information

<p>Do you currently have End-Stage Renal Disease (ESRD) – permanent kidney failure requiring regular kidney dialysis or a transplant to stay alive? 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.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>If yes, are you currently a member of Group Health?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Will you have other prescription drug coverage, including TRICARE, Federal employee health benefits coverage, VA benefits or State pharmaceutical assistance programs, in addition to the Group Health Medicare Advantage plan?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>If yes, name of other plan _____ ID # for other plan _____ Group # for other plan _____</p>	
<p>Since you became eligible for Medicare, have you had any prescription drug coverage or any insurance that included drugs?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>If you answer no, your premium may be increased because of late enrollment penalty. If you answer yes, we may ask you for proof that your previous prescription drug coverage was at least as good as Medicare’s standard prescription drug coverage (creditable prescription drug coverage). You can send copies of your proof with this form or you can wait until we ask for it. You don’t have to send your proof to enroll. However, if we ask for your proof and you don’t provide it, your premiums may be increased because of a late enrollment penalty. For more information about the late enrollment penalty, visit www.medicare.gov or call 1-800-MEDICARE.</p>	
<p>Do you live in an institution? If yes, please provide the following:</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Name of institution _____ Date you were admitted to institution _____</p>	
<p>Address of institution _____ Phone number of institution _____</p>	
<p>Are you enrolled in a State Medicaid program? If yes, Medicaid number _____</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Do you or your spouse work?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>

Employer group applicants please complete this section

Are you enrolling through an employer group plan? Yes <input type="checkbox"/> No <input type="checkbox"/>	Employer group name	Group number
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Individual applicants please complete this section

Select only one Group Health Medicare Advantage plan

<input type="checkbox"/> Medicare Advantage	<input type="checkbox"/> Medicare Advantage Prescription Drug plan	<input type="checkbox"/> Medicare Advantage High-Option Prescription Drug plan
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In addition to the Medicare Advantage plan you selected, do you want the optional dental benefit? Yes No

Plan premium payment option – select only one

Direct billing – Group Health will send you a monthly billing statement.

Group Health automatic payment plan – If you choose this option your monthly premium for the Group Health Medicare Advantage plan you selected will be deducted from your bank account. To enroll in the Automatic Payment Plan, complete the Group Health Transfer of Funds form.

You can also have the monthly premium for this Medicare plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month which you can pay by mail or by the Group Health automatic payment plan. Generally you must stay with the option you choose for the rest of the year. If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. **Before deciding on SSA Withholding, please contact the Group Health Customer Service Center at 1-888-901-4600 TTY 1-800-833-6388 or 711 for additional information. You cannot select SSA Withholding with this form.**

Sign here (please read both sides, fill in all information requested, and sign where indicated below.)

Your signature	Today's date
If you are the authorized representative, please attest to this by providing the following information. Proof of your authority must be presented to Group Health Cooperative upon request.	
Name	
Relationship to applicant	
Address	
Phone ()	

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Release of 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. 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 Group Health Cooperative or by Medicare.

Important message regarding SSA withholding

The first time premiums are withheld from your Social Security benefit, you should expect that two monthly premium amounts will be withheld at the same time. In some cases, it could take three months and three months worth of premiums could be deducted at the same time. You will never have a deduction that is more than three months worth of premiums. If for any reason your Social Security premium withhold request is delayed longer than three months, Medicare will stop your request and ask your Medicare drug plan to bill you directly for premiums.

Employer group or union group coverage

If you currently have health coverage from an employer or union, joining one of the Group Health Medicare Advantage plans could affect your employer or union health benefits. If you have health coverage from an employer or union, joining one of the Group Health Medicare Advantage plans may change the way your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their Web site, 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 questions about your coverage can help.

Please read and agree to each statement below. Your signature on the front of this document shows that you have read, understood, and agreed to these statements.

Group Health Medicare Advantage plans are coordinated care plans. I will need to keep my Parts A and B Medicare coverage. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform Group Health of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Group Health Medicare Advantage or by calling 1-800-MEDICARE. TTY users should call 1-877-486-2048.

Group Health Medicare Advantage plans serve a specific service area. If I move out of the area that Group Health Medicare Advantage plans serve, 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 a Group Health Medicare Advantage plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Group Health when I receive it, to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

By enrolling in this plan I will automatically be disenrolled from any other Medicare plan, including a Medicare Health Plan (Medicare Advantage and Medicare Cost plans) of which I am currently a member. It is my job to tell Group Health about other prescription drug coverage or expected reimbursement (also called "third party coverage") for prescription drugs. If I intentionally misrepresent this information, Medicare requires the plan to disenroll me if this plan has Medicare drug coverage. I understand that beginning on the date my Group Health Medicare Advantage plan coverage begins, I must get all of my health care from Group Health with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico. Services authorized by Group Health and other services contained in my Group Health Medicare Advantage Evidence of Coverage will be covered. Without authorization, **NEITHER MEDICARE NOR GROUP HEALTH WILL PAY FOR THE SERVICES.**

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Please fill in the blanks on the front of this page with the information on your Medicare card and attach a copy of your Medicare card or your letter of verification from the Social Security Administration or Railroad Retirement Board. You must have Medicare Parts A and B to join a Medicare Advantage plan.

Medicare	Health insurance
CENTERS FOR MEDICARE & MEDICAID SERVICES	
NAME OF BENEFICIARY JANE SMITH	
MEDICARE CLAIM NUMBER 123-45-6789-A	SEX FEMALE
IS ENTITLED TO HOSPITAL (PART A) MEDICAL (PART B)	EFFECTIVE DATE 11-1-98 11-1-98
SIGN HERE _____	

To obtain information or to ask questions regarding this information, please call Group Health Customer Service staff Monday through Friday, from 8 a.m. to 6 p.m. and Saturdays from 9 a.m. to 2 p.m. at 1-888-901-4600. From November 15, 2006 to March 1, 2007, we will offer extended hours; 8 a.m. to 8 p.m., seven days a week. Or call TTY Relay (for the hearing- or speech-impaired) at 1-800-833-6388 or 711.

Office use only:

Name of staff member (if assisted in enrollment) _____

Consumer number _____

Group number _____

Effective date of coverage _____ / _____ / _____ (MM/DD/YYYY)

ICEP/EP OEP AEP SEP (reason if SEP) _____