Senior Care Plus

A Medicare Advantage Plan from Hometown Health.

Please contact Senior Care Plus if you need information in another language or format (Braille)
Senior Care Plus complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

To Enroll in Senior Care Plus, Please Provide the Following Information:				
Please check which plan you want to enroll in:				
☐ **$100.80 Standard-001** (PDP)				
LAST Name:	FIRST Name:		Middle Initial:	☐Mr. ☐Mrs. ☐Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐M ☐F	Home Phone #:		Alternate Phone #
Permanent Residence Street Address (P.O. Box is not allowed):				Apt #:
City:	County:	State:		Zip Code:
Mailing Address (only if different from your Permanent Address):				
Address:	Apt #:	City:	State:	Zip Code:
E-mail Address:				
Optional- Emergency Contact Name:				
Phone #:		Relationship to You:		

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 Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card): _____ Medicare Number: _____ 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

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail Electronic Funds Transfer (EFT), 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. 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 RRB. DO NOT pay the Part D-IRMAA extra amount to *Senior Care Plus*.

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, 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 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 payment invoice each month.

Please select a premium payment option:

☐ **Monthly Invoice**

☐ **One-Time Credit Card**- *may only be made in a Senior Care Plus office*

☐ **Re-occurring credit card** - *may only be made in a Senior Care Plus office*

☐ **Electronic Fund Transfer (EFT)** from your bank account each month. Please enclose a VOIDED check.

Account holder name: _____

Bank name: _____

Bank routing number: _____Bank account number_____

Account type: ☐ Checking ☐ Savings

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check**

I get monthly benefits from: ☐ Social Security ☐ RRB

(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 Answer the Following questions:

1. 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 Senior Care Plus? ☐ 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:_____

2. 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):_____

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

☐ Spanish ☐ Other:_____ ☐ Braille ☐ Audio Tape ☐ Large Print

Please contact Senior Care Plus at 775-982-3112 or 888-775-7003 if you need information in another format or language than what is listed above. TTY users should call the State Relay at 711. Hours are Monday through Sunday, 7:00 am to 8:00 pm. We will be closed Thanksgiving Day and Christmas Day.

Please Read This Important Information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining Senior Care Plus Prescription Drug Plan, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the

information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

If you currently have health coverage from an employer or union, joining Senior Care Plus Prescription Drug Plan (PDP) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Senior Care Plus PDP. 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

Senior Care Plus is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Senior Care Plus Prescription Drug Plan of any prescription drug coverage that I have or may get in the future.

I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in Senior Care Plus (PDP) will end that enrollment.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

Senior Care Plus PDP serves a specific service area. If I move out of the area that Senior Care Plus PDP serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Senior Care Plus PDP network pharmacies. Once I am a member of Senior Care Plus PDP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Senior Care Plus PDP when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and 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 in addition to my premium for Medicare prescription drug coverage in the future.

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

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

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that Senior Care Plus will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Senior Care Plus 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 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 Medicare.

Applicant 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:

State Law requires proof of Legal Guardian, Durable Power of Attorney for Health Care decisions (DPAHC) or written Advance Directive. Please attach copy of documents. If someone other than yourself helped you complete this form, he/she must sign above.

OFFICE USE ONLY:

Name Sale Rep:_____

Sales Rep Signature:

_____

Enrollment Location:_____ Effective Date: _____

Entry Date:_____

SCP Assigned MBR #:_____Contract:_____

Election Period: ☐A-AEP ☐E-IEP/ICEP ☐O-OEPI ☐U-SEP ☐W-SEP ☐S-SEP

PBP:_____ Welcome Call: ☐W ☐ E Special

Services:_____

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TrOOPBal:_____ ☐Not Eligible ☐DST ☐Marx ☐COB ☐POA