

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:

Medicare Advantage Plan with Prescription Drug Coverage:

\$0 Value Rx Complete-019 (HMO)

This plan includes preventative dental at no additional monthly premium. Please see the *2019 Value Rx Complete Evidence of Coverage* for full benefit details.

OR **\$30 includes Optional Comprehensive Dental:** Includes basic services covered at 80%, and major services covered at 50%, with a \$100 annual deductible. Please see the *2019 Value Rx Complete Evidence of Coverage* for full benefit details.

LAST Name:	FIRST Name:	Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date: (__/__/____) (MM / DD / YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone #:	Alternate Phone #
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Permanent Residence Street Address (P.O. Box is not allowed):	Apt #:
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City:	County:	State:	Zip Code:
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Mailing Address (only if different from your Permanent Address)

Address:	Apt #:	City:	State:	Zip Code:
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E-mail Address:

Optional- Emergency Contact Name:

Phone #:	Relationship to You:
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Please Provide Your Medicare Insurance Information

<p>Please take out your Medicare card to complete this section.</p> <ul style="list-style-type: none"> 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) _____
<p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>	

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, 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 Senior Care Plus 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, 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 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 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: _____

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

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 another format:

Spanish Other: _____ Braille Audio Tape Large Print

Please contact Senior Care Plus at 702-914-0863 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 all federal holidays, except New Year's Day.



Please Read This Important Information

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

By completing this enrollment application, I agree to the following:

Senior Care Plus 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.

Senior Care Plus serves a specific service area. If I move out of the area that Senior Care Plus 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 Senior Care Plus, 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 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 Senior Care Plus coverage begins, I must get all of my health care from Senior Care Plus, except for emergency or urgently needed services or out-of-area dialysis services.

I understand that beginning on the date Senior Care Plus coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Senior Care Plus provides refunds for all covered benefits, even if I get services out of network. Services authorized by Senior Care Plus and other services contained in my Senior Care Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered.

Without authorization, **NEITHER MEDICARE NOR Senior Care Plus 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 Senior Care Plus, he/she may be paid based on my enrollment in Senior Care Plus.

Release of Information: By joining this Medicare health 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 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.

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.

BROKER / OFFICE USE ONLY:

Name Sale

Rep: _____

Sales Rep Signature: _____

Enrollment Location: _____

Effective Date: _____

NPN: _____

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