Senior Care Plus
A Medicare Advantage Plan from Hometown Health

2019 Annual Abbreviated Election Form

You are Currently Enrolled In: (Current Plan Information)
Member Number:
Name:
Address:
City, State, Zip:

If You Would Like To Change Plans for 2019; If you are selecting a different plan, health benefits and monthly premium may change. Please Mark One Box:

Medicare Advantage Plan without Prescription Drug Coverage:

☐ **$0 Value Basic-009** (HMO) ($20 Part B Premium Rebate)

This plan does not offer supplemental benefits. Please see the *2019 Value Basic Evidence of Coverage* for full benefit details.

STOP **By Initialing The Line Below, I Acknowledge That The Medicare Advantage Plan I've Selected Does Not Have Prescription Drug Coverage _____.**

Medicare Advantage Plans with Prescription Drug Coverage:

☐ **$0 Value Rx-012** (HMO)

This plan does not offer supplemental benefits. Please see the *2019 Value Rx Evidence of Coverage* for full benefit details.

☐ **$45 Value Rx Enhanced-004** (HMO)

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

☐ **$180 Value Rx Select-018** (HMO)

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

☐ **Keep My Current Plan Type**
By Selecting This Option, You Acknowledge That You Understand Any Health, Premium, and Benefit Changes In Your Current Plan For 2019.

Email Address (Optional):

If different from above, your Primary Care Physician (PCP) selected from our list of Doctor's:

Please list any Durable Medical Equipment currently used (oxygen, c-pap, wheelchair, etc.):

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: ☐English ☐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 all federal holidays, except New Year's Day.

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 (at Senior Care Plus, 10315 Professional Circle) each month. You can also 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 Senior Care Plus.

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail, Electronic Funds Transfer (EFT), credit card (must be done at a Senior Care Plus Office) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board 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 Railroad Retirement Board. 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 you qualify, 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 won't have a coverage gap or a late enrollment penalty. Many people qualify 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 for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

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.

If you don't select a payment option, you will get a monthly invoice

☐ **I have extra assistance through Medicare and/or Nevada Senior Rx** and have a reduction in my premium.

☐ **Electronic Funds Transfer (EFT)** – I hereby authorize Senior Care Plus to deduct the premium amount selected above from my checking/savings account on or after the **5th** of each month.

Account holder name_____

Bank routing number: _____**Bank account number**_____

Bank name _____

Account type: ☐ **Checking** ☐ **Savings**

☐ **Monthly Invoice** (Direct self-pay) –You will receive monthly invoices beginning January 1, 2019.

☐ **Credit Card** – (Major credit cards) Payments can only be made at a Senior Care Plus office.

☐ **Re-occurring credit card payments -** (Major credit cards) Payments can only be made at a Senior Care Plus office

☐ **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 Sign Below

Senior Care Plus is a plan that has a contract with the Federal government.

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 the Medicare health plan 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 people with Medicare aren't 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. 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 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.