Senior Care Plus

A Medicare Advantage Plan from Hometown Health.

Premium Payment Change Form

This form must be completed and received by Senior Care Plus by the end of the month in order for your change to be effective the 1st of the next month or a later effective date.

Last Name:	First Name:	Middle Initial:
Member #:	Effective Date:	

Please check your Payment option:

☐ **Electronic Funds Transfer (EFT)** – By checking this box, you hereby authorize Senior Care Plus to deduct the premium amount selected above from your checking/savings account on or after the **5th** of each month.
You must attach your *Voided Check* when returning this form to start the EFT process.

☐ **Monthly Premium Payment Slips** –You will receive monthly premium payment slips through the mail.

☐ **Credit Card** – (Major credit cards) Please come into the Senior Care Plus office to use your credit card

☐ **Deduction from Social Security Check** – By signing the bottom of this form, and checking this box**,** you hereby authorize Social Security Administration to deduct your Senior Care Plus premium directly from your Social Security check. **It may take 2 to 3 months for my deduction to be taken out of my Social Security check at a lump sum amount.**

RETURN COMPLETED FORM TO:
SENIOR CARE PLUS
10315 Professional Circle
Reno, NV 89521
ATTN: ENROLLMENT

People with limited incomes may qualify for extra help to pay for prescription drug costs. If eligible, Medicare could pay for 75% of 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 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY users call 1-877-486-2048. 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 Medicare does not cover. Please select a payment method above for the remaining premium, if any. Selection of payment method is required, even if you have a reduction in premium. If we have determined that you owe a late enrollment penalty, we will need to know how you would prefer to pay.

Signature:	**Date:**