Senior Care Plus

A Medicare Advantage Plan from Hometown Health.

Senior Care Plus Medicare Advantage Enrollment Form

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security(or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to: Senior Care Plus 10315 Professional Circle, Reno NV 89521

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Senior Care Plus at 775-982-3112 or toll free at 888-777-7003 TTY users can call (711)

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Senior Care Plus al 775-9823158/TTY o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia enespañol y un representante estará disponible paraasistirle.

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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 without Prescription Drug Coverage:

☐ **$0 Patriot Plan-009** (HMO) ($50 Part B Premium Rebate)

This plan includes preventative dental at no additional monthly premium. Please see the *2022 Patriot Plan 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 Essential Plan-012** (HMO)

This plan includes preventative dental at no additional monthly premium. Please see the *2022 Essential Plan Evidence of Coverage* for full benefit details.

☐ **$0 Renown Preferred Plan by Senior Care Plus-023** (HMO)

This plan includes comprehensive dental at no additional monthly premium. Please see the *2022 Renown Preferred Plan by Senior Care Plus Evidence of Coverage* for full benefit details.

☐ **$180 Select Plan-018** (HMO)

This plan includes comprehensive dental at no additional monthly premium. Please see the *2022 Select Plan Evidence of Coverage* for full benefit details.

☐ **$31.70 Extensive Duals Plan-024** (HMO D-SNP)

This plan includes comprehensive dental at no additional monthly premium. Please see the *2022 Extensive Duals Plan Evidence of Coverage* for full benefit details.

STOP **By Initialing The Line Below, I Acknowledge That I qualify for the Special Needs plan I have selected. _____.**

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: _____ You must have Medicare Part A and Part B to join a Medicare Advantage plan.

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.

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 *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.)

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

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. Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

3. Medicaid #_____ Date Medicaid Effective _____

Please choose the name of a Primary Care Physician (PCP), clinic or health center:

Select one if you want us to send you information in a language other than 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-Sunday, 7am-8pm (October 1st - March 31st); and Monday-Friday, 7am-8pm (April 1st - Sept 30th). We will be closed on all Federal holidays.

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.

I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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.

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:_____

_

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

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date)_____.
- ☐ I recently was released from incarceration. I was released on (insert date)
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date)_____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date)__.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date)_____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date)__.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I recently left a PACE program on (insert date)_____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date)_____.
- ☐ I am leaving employer or union coverage on (insert date)_____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date)_____.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification

required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you are not sure, please contact Senior Care Plus at 888-775-7003 (TTY users should call the State Relay Service at 711) to see if you are eligible to enroll. We are open Monday-Sunday, 7am-8pm (October 1st - March 31st); and Monday-Friday, 7am-8pm (April 1st - Sept 30th). We will be closed on all Federal holidays.