MEDICAL MUTUAL OF OHIO®
YOUR HEALTHCARE PARTNER SINCE 1934

Advantage

Medicare Advantage Plans *from Medical Mutual*

Enrollment Application

(MA-PD)

Please complete this application to enroll in Advantage Plan from Medical Mutual of Ohio®

PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining Advantage Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Advantage Plan. Read the communications your employer or union sends you. If you have questions, visit their Web site, 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.

Medical Mutual Office Use Only

Coverage Selected by Applicant

☐ Advantage Plan MSA Optimum$_X$ ($170 per month)
☐ Advantage Plan Non-MSA Optimum$_X$ ($210 per month)
☐ Advantage Plan Secure$_X$ ($58 per month)

Name of Staff Member, Agent or Broker (If Assisted in Enrollment)			**Plan ID Number**		**Effective Date**
Annual (A)	**Open (O/N)**	**Initial (I)**	**Dual Eligible (U)**	**Move (V)**	**Other (S)**
Name of Agent/Broker			**Agent Telephone Number**		**Agent Tax ID**
Name of Agency		**Royal Advantage® Broker** (If Applicable)			**Broker Certification Verified** ☐ Yes ☐ No

1. Applicant Information

Last Name		First Name		MI
Birthdate / /	**Sex** ☐ Male ☐ Female	**Title** ☐ Mr. ☐ Mrs. ☐ Ms.	**Home Phone Number** ( ) –	
E-Mail Address			**Alternate Phone Number** ( ) –	
Permanent Address (Residence—P.O. Box is not allowed)				
City		State	Zip Code	
Mailing Address (Only if different from your Permanent Address listed above)				
City		State	Zip Code	
Emergency Contact Person		**Relationship to Applicant**	**Home Phone Number** ( ) –	

2. Medicare Information (Use your Medicare card to complete this section)

Please fill in the blanks so that they match your red, white and blue Medicare card or attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board. **You must have Medicare Part A and Part B to join a Medicare Advantage plan.**

Medicare Claim Number	Hospital (Part A) Effective Date	Medical (Part B) Effective Date
– –	/ /	/ /

3. Plan Selection

Please select the Advantage Plan you would like to enroll in:

☐ Advantage Plan MSA Optimum$_X$ ($170 per month)
☐ Advantage Plan Non-MSA Optimum$_X$ ($210 per month)
☐ Advantage Plan Secure$_X$ ($58 per month)

4. Provider Information (Please choose a Primary Care Physician from the Advantage Plan provider directory.)

Name of Primary Care Physician (PCP)

5. Paying Your Plan Premium

You can pay your monthly premium by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security Benefit Check each month.

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 800/772-1213. TTY users should call 800/325-0778. You can also apply for extra help online at 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 your premium, we will bill you for the amount Medicare doesn't cover. If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ **Get a bill each month**

☐ **Automatic deduction from your monthly SSA benefit check.**
The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA Benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.

☐ **Electronic Funds Transfer (EFT) from your bank account**
Please enclose a voided check or provide the following information:

Account Type
☐ Checking Account
☐ Savings Account

Bank Routing Number

Bank Account Number

Account Holder Name ____________________

6. Please answer the following questions

☐ **Yes** ☐ **No** — **1. Do you have End Stage Renal Disease (ESRD)?** If you answered "Yes" to this question and you don't need regular dialysis anymore, or if you have had a successful kidney transplant, please attach a note or records from your doctor showing you don't need dialysis or have had a successful kidney transplant.

☐ **Yes** ☐ **No** — **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 Advantage Plan?** If "Yes," please list your other coverage and your identification (ID) numbers(s) for this coverage:

Name of Coverage	ID Number	Group Number

☐ **Yes** ☐ **No** — **3. Are you a resident in a long-term care facility, such as a nursing home?** If "Yes," please provide the following information:

Name of Institution	Phone Number
Address	

☐ **Yes** ☐ **No** — **4. Are you enrolled in your State Medicaid program?** If "Yes," please provide your Medicaid number.

Medicaid Number	

☐ **Yes** ☐ **No** — **5. Do you or your spouse work?**

7. Please check all that apply

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you don't add or drop your prescription drug coverage (i.e. if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage you can only change to another plan without Medicare prescription drug coverage).

Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods. 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 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 have both Medicare and Medicaid or my state helps pay for my Medicare premiums.

☐ I get extra help paying for Medicare prescription drug coverage.

☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____/_____/_____.

☐ 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.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____/_____/_____.

☐ None of these statements applies to me.*

* Please contact Medical Mutual at 800/982-3117 (TTY users should call 800/982-8109) to see if you are eligible to enroll. We are open Monday through Friday, 8 a.m. to 8 p.m. EST.

8. Terms and Conditions

By completing this enrollment application, I agree to the following:
Advantage Plan 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 only be in 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: November 15 – December 31 of every year), or under certain special circumstances.

Advantage Plan serves a specific service area. If I move out of the area that Advantage Plan 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 Advantage Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the member Handbook from Advantage Plan when I get it to know which rules I must follow in order 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 Advantage Plan coverage begins, I must get all of my healthcare from Advantage Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Advantage Plan and other services contained in my Advantage Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor Advantage Plan 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 Medical Mutual he/she may be paid based on my enrollment in Advantage Plan.

Release of Information
By joining this Medicare health plan, I acknowledge that Advantage Plan will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that Advantage Plan 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 by Advantage Plan or by Medicare.

Applicant's Signature	**Date** / /

IF YOU ARE THE AUTHORIZED REPRESENTATIVE, YOU MUST PROVIDE THE FOLLOWING INFORMATION:

Authorized Representative's Signature (If Needed)	**Date** / /

Representative's Address		
City	State	Zip Code

Relationship to Applicant	**Home Phone Number** ( ) –

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