Enrollment instructions

Thank you for choosing a Medicare plan from Priority Health. Follow these helpful tips to avoid delays in processing your enrollment.

Make sure to complete the entire enrollment form and don't forget to sign.

To confirm that your doctor, clinic or health center is part of the Priority Health Medicare network of providers, go to *priorityhealth.com/findadoc* or call our Medicare experts at the phone number listed below.

Enrollment form checklist:

Make sure to:

- ☐ Choose a selection on page 1 that applies to you.
- ☐ Choose a Primary Care Provider (PCP) (if applicable).
- ☐ Complete your Medicare Insurance information from your Medicare red, white and blue card or attach a photocopy of your Medicare card as proof that you have Medicare Parts A and B coverage.
- ☐ Answer all five questions in section 2 of the form.
- ☐ Sign and date the form.

Mail your completed enrollment form in the enclosed postage-paid envelope. Or, if you do not have a postage-paid envelope, you can send your completed enrollment form to Priority Health, MS 1175, 1231 E. Beltline, Grand Rapids, MI 49525.

The provider and pharmacy directory and formulary are available on *prioritymedicare.com*.

If you have any questions call our Medicare experts toll-free at 888.389.6648 (press #3). Our office hours are 8 a.m. to 8 p.m., seven days a week. TTY users should call 711.

Priority Health Medicare employer group enrollment request form

PriorityHealth

Attestation of eligibility for an enrollment period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period. Because you are enrolling in an employer group plan, work with your benefits administrator if you have questions. Your employer may have guidelines about when you are eligible to enroll in a Medicare Advantage plan.

Please read the following statements carefully and check the box for the statement that 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 in incorrect, you may be disenrolled.

Choose one of the following:

☐I am new to Medicare (example: recently enrolled in Medicare parts A and B).
☐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 am electing to enroll during the annual enrollment period (Oct. 15 through Dec. 7).
☐I am leaving employer or union coverage on (insert date) ____/____/____ (example: retiring and losing coverage through an employer).
☐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 currently have Medicare Parts A and B due to disability and am turning 65 years of age.
☐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).
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 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) ____/____/____
☐My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
☐I am enrolling during my "open enrollment."
☐I currently have Medicare Parts A and B and am turning 65 years of age.
☐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 recently was released from incarceration. I was released on (insert date) ____/____/____.
☐I recently obtained lawful presence status in the United States. I got this status on (insert date) ____/____/____.
If none of these statements apply to you, please contact Priority Health to see if you are eligible to enroll. Call toll-free 888.389.6648 (press #3) (TTY users should call 711). Our office hours are 8 a.m. to 8 p.m., seven days a week. You can also reach out to your benefits administrator with questions.
☐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.

Office use only	
Effective date of coverage _____	Group number _____
ICEP / IEP / AEP / SEP (type) _____	Subscriber ID _____
PBP ID	
Processing rep _____ Date processed ____/____/____	

For employer use only

Group name	Effective date ____ /____ /____	Employee ID (required)
Group signature		Date ____ /____ /____

Please select the appropriate plan for this contract:

PriorityMedicare℠ (Employer HMO-POS) ☐ Prime ☐ Basic ☐ Custom ☐ Essential ☐ Enhanced

PriorityMedicare℠ (Employer PPO) ☐ Elevate ☐ Custom

PriorityMedicare Rx℠ (Employer PDP) ☐ Custom

Section 1 – Enrollment information

If enrollee is Medicare eligible, please record name as it appears on his or her Medicare card.

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.	Subscriber's last name	First name	M.I.	Social Security number – –

Permanent Address (P.O. Box is not allowed)

City	County	State	ZIP code

Mailing address (only if different from your permanent address)

City	County	State	ZIP code

Birth date ____ /____ /____ (MM/DD/YYYY)	Sex ☐ Male ☐ Female	Race (optional) ☐ Hispanic/Latino ☐ Black/African American ☐ White/Caucasian ☐ Other ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander

Phone number that we may use to contact you: ( ) ☐ Landline (home phone) ☐ Mobile phone	Alternate number that we may use to contact you: (optional) ( ) ☐ Landline (home phone) ☐ Mobile phone

Email address	Please include your email if you would like to opt-in to receiving plan documents and other health and plan information by email. You can unsubscribe at any time by clicking the link provided in any email you receive from us.

Subscriber's Priority Health primary care provider (PCP).
Please choose the name of a PCP, otherwise one will be assigned to you (if applicable). You may change your PCP at any time.

Have you seen this provider? ☐ Yes ☐ No	First name of PCP: Last name of PCP:

Are you Medicare eligible? ☐ Yes ☐ No (If no, please skip to Section 3-Authorization. If yes, please complete questions 1-4 in section 2.)

Spouse / dependent's last name	First name	M.I.	Social Security number – –

Birth date ____ /____ /____ (MM/DD/YYYY)	Sex ☐ Male ☐ Female	Race (optional) ☐ Hispanic/Latino ☐ Black/African American ☐ White/Caucasian ☐ Other ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander

Please choose the name of a PCP, otherwise one will be assigned to you (if applicable). You may change your PCP at any time.

Have you seen this provider? ☐ Yes ☐ No	First name of PCP: Last name of PCP:

Is this spouse / dependent Medicare eligible? ☐ Yes ☐ No (If yes, please complete questions 1-4 in section 2.)

Dependent's last name	First name	M.I.	Social Security number – –

Birth date ____ /____ /____ (MM/DD/YYYY)	Sex ☐ Male ☐ Female	Race (optional) ☐ Hispanic/Latino ☐ Black/African American ☐ White/Caucasian ☐ Other ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander

Please choose the name of a PCP, otherwise one will be assigned to you (if applicable). You may change your PCP at any time.

Have you seen this provider? ☐ Yes ☐ No	First name of PCP: Last name of PCP:

Is this dependent Medicare eligible? ☐ Yes ☐ No (If yes, please complete questions 1-4 in section 2.)

Premiums

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 coinsurance. 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 *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 employer premium. If Medicare pays only a portion of this premium, your employer group will bill you for the amount that Medicare doesn't cover.

If we determine that you owe a late enrollment penalty, your employer will bill you for this amount.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition in any employer premium you may have. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare. DO NOT pay Priority Health or your Employer group the Part D-IRMAA.

Section 2 – Medicare and other information

1. Please refer to 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.
   You must have Medicare Part A and Part B to join a Medicare Advantage plan.

   Subscriber's Medicare Number _____
   Hospital (Part A) effective date ____ /____ /____ Medical (Part B) effective date ____ /____ /____

   Spouse/dependent's Medicare Number _____
   Hospital (Part A) effective date ____ /____ /____ Medical (Part B) effective date ____ /____ /____

   Dependent's Medicare Number _____
   Hospital (Part A) effective date ____ /____ /____ Medical (Part B) effective date ____ /____ /____

2. Does any covered member have End-Stage Renal Disease (ESRD)?
   Subscriber: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No Dependent: ☐ Yes ☐ No

   If you or your spouse or dependent has had a successful kidney transplant and/or don't need regular dialysis any more, please attach a note or records from the doctor showing a successful kidney transplant or that dialysis is not needed, otherwise we may need to contact you/spouse/dependent to obtain additional documentation.

3. Is any enrollee a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If yes, please provide the following information:

   Member name _____ Name of institution _____

   Address and phone number of institution (number and street) _____

4. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefit coverage, VA benefits, or State pharmaceutical assistance. Does any enrollee have other prescription drug coverage in addition to Priority Health Medicare? If so, please complete the information below:

   Member name _____ Name of other coverage _____
   ID # _____ Group #_____

5. Is any enrollee enrolled in your State Medicaid program?

   Subscriber: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No Dependent: ☐ Yes ☐ No
   Medicaid ID #: _____ Medicaid ID #:_____ Medicaid ID #:_____

6. Do you or your spouse work? Subscriber: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

If you would prefer us to send you information in another format or language, please contact Priority Health Medicare. Call us toll-free at 888.389.6648, press #3 (TTY users should call 711), from 8 a.m. to 8 p.m., seven days a week.

Section 3 – Authorization

I apply for coverage for each person listed above & agree that we will abide by the Certificate of Coverage and/or Summary Plan Description and/or Evidence of Coverage that applies to our coverage. I understand that Priority Health cannot process my enrollment form on time unless I fill in all of the information above, in particular, list a PCP (if required) for my enrolled dependents and myself. All of the information I have given above is complete and correct. Priority Health requires proper handling of personal health information of our members. Details of our confidentiality policies and procedures are available upon request.

_____ Today's date ____ /____ /____

Subscriber's signature

Section 4 – Plan acknowledgement

If you or any family member listed above is Medicare eligible, please read and sign below:

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

Priority Health is a Medicare Advantage plan and has a contract with the federal government. I will need to keep my Medicare Parts A and B and I must continue to pay my Medicare Part B premium. 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. 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 ("disenroll") during the Annual Enrollment Period from October 15 - December 7 of every year (effective January 1 of the following year) or under certain limited special circumstances.

Priority Health Medicare serves a specific service area. If I move out of the area that Priority Health Medicare serves, I need to notify Priority Health Medicare so I can disenroll and find a new plan in my area. Once I am a member of Priority Health Medicare, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Priority Health Medicare when I receive it to know which rules I must follow in order to get coverage with this Medicare Advantage plan. I understand that Priority Health Medicare provides coverage for me in the United States and around the world for emergency and urgent care.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Priority Health Medicare, he/she may compensated based on my enrollment in Priority Health Medicare.

For HMO-POS plan enrollees: I understand that beginning on the date Priority Health Medicare coverage begins, I must get all of my health care from Priority Health Medicare network providers, except for emergency or urgently needed services, out-of-area dialysis services and out-of-network services explicitly covered under my Priority Health Medicare Point of Service (POS) benefit plan. Services authorized by Priority Health Medicare and other services contained in my Priority Health Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, neither Medicare nor Priority Health Medicare will pay for the services.

For PPO plan enrollees: I understand that beginning on the date that Priority Health Medicare 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, Priority Health Medicare provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Priority Health Medicare and other services contained in my Priority Health Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, neither Medicare nor Priority Health Medicare will pay for the services.

Release of information: By joining this Medicare health plan, I acknowledge that Priority Health Medicare will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Priority Health Medicare 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.

_____ Today's date ____ /____ /____

Subscriber's signature

_____ Today's date ____ /____ /____

Spouse's signature

_____ Today's date ____ /____ /____

Dependent's signature

If you are the authorized representative, you must provide the following information:

Name _____ Relationship to enrollee _____

Address _____ Phone _____

Priority Health has HMO-POS and PPO plans with a Medicare contract. Enrollment in Priority Health Medicare depends on contract renewal.

NCMS_Y0056_100010701900A_M 09102018 10502X 08/18