AdvantagePlan
from Medical Mutual of Ohio®

To Enroll in Advantage Plan from Medical Mutual of Ohio® Please Provide the Following Information:			
Please check which plan you want to enroll in: Advantage Plan Standard ______ Value ______ Premium ______ **Please choose the name of a Primary Care Physician (PCP):**______________________________			
Last Name: ________________________ First Name: ____________________ MI __			Mr. Mrs. Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex M F	Social Security Number: ***(providing this information is optional)***	Home Phone Number: ( )______-__________
Permanent Residence Street Address:			
City:	State:		ZIP Code:
Mailing Address (only if different from your Permanent Residence Address): Street Address:_________________________ City:________________ State:_________ ZIP ________			
Emergency contact: ____ **Phone Number:** ( )_________- ___________ **Relationship to You** _____________________			
E-mail Address:			
Please answer the following questions: **1. Do you have End Stage Renal Disease (ESRD)? Yes No** If you answered "yes" to this question and you do not need regular dialysis anymore, or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant.			
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? 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:** ______________			
3. Are you a resident in a long-term care facility, such as a nursing home? Yes No **If "yes" please provide the following information:** **Name of Institution:** ________________________________ **Address:** ________________________________ **Phone Number:**________________________________			

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4. **Are you enrolled in your State Medicaid program? Yes No**

If yes, please provide your Medicaid number: ____

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

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if there is any, deducted from your monthly check.

Would you like the Premium for this plan deducted from your Social Security monthly benefit check? Yes No

Your Signature: ____	**Today's Date:** _________________________

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

Name: ____

Address: ____

Phone Number: (______) ____________- ____________

Relationship to Enrollee ___________________________

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 the Social Security Administration or Railroad Retirement Board.

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

SAMPLE ONLY

Name: ____________________________________

Medicare Claim Number Sex ___

__ __ __ - __ __ - __ __ __ __ ___

Is Entitled To: Effective Date: ____________

HOSPITAL (Part A) _______________

MEDICAL (Part B) _______________

Your Plan Premium Option

You can have the monthly premium for this Medicare plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month, which you can pay by mail or by Electronic Funds Transfer (EFT). Generally you must stay with the option you choose for the rest of the yer.

Stop. 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.

If you have health coverage from an employer or union, joining Advantage Plan may change how your current coverage works. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read

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

Advantage Plan is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. 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. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Advantage Plan from Medical Mutual or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

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 receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

I understand that beginning on the date Advantage Plan coverage begins, I must get all of my healthcare from Advantage Plan, with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico. 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 STAND-ALONE DRUG WILL PAY FOR THE SERVICES.**

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 healthcare operations. 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 behalf of the individual under the laws of the State where the individual resides) 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.

Office Use Only:

Name of staff member (if assisted in enrollment): ____________________

Plan ID #: ____________________

Effective Date of Coverage: ____________________

ICEP/IEP: __________ OEP: __________ AEP: __________ SEP (type): __________

Sold – Account Executive and Code	Agent of Record	Tax I.D.
Service – Account Executive and Code	Royal Advantage® Broker	Commission Indicator

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from Medical Mutual of Ohio®

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