PASSPORT ADVANTAGE (HMO SNP)

# ENROLLMENT REQUEST FORM

Please contact Passport Advantage (HMO SNP) if you need information in another language or format (Braille).

**To Enroll in Passport Advantage, Please Provide the Following Information:**

| LAST Name: | FIRST Name: | Middle Initial: | ❑ Mr. ❑ Mrs. ❑ Ms. |
|---|---|---|---|

| Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y) | Sex: ❑ M ❑ F | Home Phone Number: ( ) | *(Optional)* Alternate Phone Number: ( ) |
|---|---|---|---|

**Permanent Residence Street Address** (P.O. Box is not allowed):

| City: | *(Optional)* County: | State: | ZIP: |
|---|---|---|---|

**Mailing Address** (only if different from your Permanent Residence Address):
Street Address: _____ City: _____ State: _____ ZIP Code: _____

*(Optional)* **Emergency contact:** _____
**Phone Number:** _____ **Relationship to You:** _____

*(Optional)* **E-mail Address:**

**Please Provide Your Medicare Insurance Information**

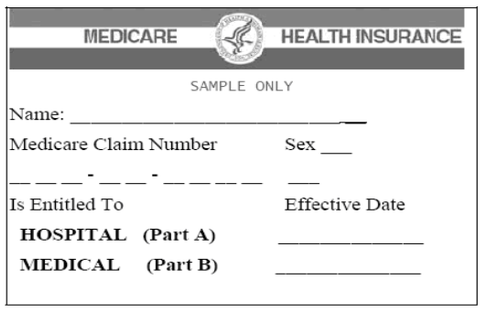
Please take out your Medicare card to complete this section.

- 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.

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


MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: _____

Medicare Claim Number Sex ___

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

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

**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 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 the RRB. DO NOT pay Passport Advantage 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 bill each month.

**Please select a premium payment option:**

❑ Get a bill

❑ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. *(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.)*

**Please read and answer these important questions:**

1. Do you have End-Stage Renal Disease (ESRD)? ❑ Yes ❑ No

   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis. Otherwise, we may need to contact you to obtain additional information.

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 Passport Advantage? ❑ 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 of Institution (number and street): _____
   _____

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

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

_____

**Location:** _____

**Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format (please specify):**

❑ Braille ❑ Audio tape ❑ Large print

❑ In a language other than English (please specify): _____

Please contact Passport Advantage at 1-844-859-6152 if you need information in another format or language than what is listed above. Our office hours are Monday through Friday 8 a.m. to 8 p.m. Eastern Time from February 15 to September 30 and 7 days a week 8 a.m. to 8 p.m. Eastern Time from October 1 to February 14.


## Please Read This Important Information

**If you currently have health coverage from an employer or union, joining Passport Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Passport Advantage.** 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:**

Passport Advantage 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. 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.

Passport Advantage serves a specific service area. If I move out of the area that Passport Advantage 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 Passport Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Passport Advantage 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 Passport Advantage coverage begins, I must get all of my health care from Passport Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Passport Advantage and other services contained in my Passport Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR PASSPORT ADVANTAGE 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 Passport Advantage, he/she may be paid based on my enrollment in Passport Advantage.

**Release of Information:** By joining this Medicare health plan, I acknowledge that Passport Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Passport Advantage will release my information, including my prescription drug event data to Medicare, which may release it for research and other purposes that 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.

**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** _____

**OFFICE USE ONLY:**

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID: _____

Effective Date of Coverage: _____ Referred By: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

## Nondiscrimination Notice

Passport Advantage (HMO-SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Passport Advantage (HMO-SNP) does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

**Passport Advantage (HMO-SNP):**

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Passport Advantage (HMO-SNP).

If you believe that Passport Advantage (HMO-SNP) has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Tracy Bertram, Director of Compliance, 5100 Commerce Crossings Drive, Louisville, KY 40229, Telephone Number: 502-212-6767, TTY 771, Fax Number: 502-213-8905, Tracy.bertram@passporthealthplan.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Tracy Bertram is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

## Nondiscrimination Statement

English: Passport Advantage complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish: Passport Advantage cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

French: Passport Advantage respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

French Creole: Passport Advantage konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.

Italian: Passport Advantage è conforme a tutte le leggi federali vigenti in materia di diritti civili e non pone in essere discriminazioni sulla base di razza, colore, origine nazionale, età, disabilità o sesso.

Portuguese: Passport Advantage cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base na raça, cor, nacionalidade, idade, deficiência ou sexo.

German: Passport Advantage erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Norwegian: Passport Advantage overholder gjeldende føderale lover om borgerrettigheter og diskriminerer ikke på grunnlag av etnisitet, farge, nasjonal opprinnelse, alder, funksjonshemning eller kjønn.

Russian: Passport Advantage соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

## Nondiscrimination Statement

Persian: از قوانين حقوق مدنی فدرال مربوطه تبعيت می کند و Passport Advantage

هيچگونه تبعيضی بر اساس نژاد، رنگ پوست، اصالت ملیتی، سن، ازدواج يا جنسيت افراد

قايل نمی شود.

Greek: Passport Advantage συμμορφώνεται με τους ισχύοντες ομοσπονδιακούς νόμους για τα ατομικά δικαιώματα και δεν προβαίνει σε διακρίσεις με βάση τη φυλή, το χρώμα, την εθνική καταγωγή, την ηλικία, την αναπηρία ή το φύλο.

Serbo-Croatian: Passport Advantage pridržava se važećih saveznih zakona o građanskim pravima i ne pravi diskriminaciju po osnovu rase, boje kože, nacionalnog porijekla, godina starosti, invaliditeta ili pola.

Urdu: Passport Advantage رنگ قوانين کے وفاقی شہری حقوق کے تعميل کرتا ہے اور يہ کسی بھی نسل، قابلیت، عمر، معذوری يا جنس کی بنياد پر امتيازی نہيں کرتا۔

Hindi: Passport Advantage
ध्यान दें: अगर आप बात करने में सक्षम हैं हिंदी, तो नि शुल्क भाषा सहायता सेवाएं उपलब्ध हैं।
अपने सदस्य आईडी कार्ड या इस वेबपेज पर सूचीबद्ध नंबर पर फोन करें।

Chinese: Passport Advantage 遵守適用的聯邦民權法律規定，不因種族、膚色、民族 血統、年齡、殘障或性別而歧視任何人。

Japanese: Passport Advantage は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害または性別に基づく差別をいたしません。

Korean: Passport Advantage
주의: 한국어를 하시는 분들을 위해 무료 통역 서비스가 제공됩니다. 귀하의 회원
ID 카드 또는 본 웹페이지를 통해 제공되는 번호로 문의해 주시기 바랍니다.

Vietnamese: Passport Advantage tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Tagalog: Sumusunod ang Passport Advantage sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

## Multi-Language Interpreter Services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-859-6152 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-859-6152 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-859-6152（TTY：711）.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-859-6152 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-859-6152 (TTY: 711).

إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-859-2516 (رقم هاتف الصم والبكم: 117). ملحوظة:

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-844-859-6152 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-859-6152（TTY：711）まで、お電話にてご連絡ください。

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-859-6152 (TTY:711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-859-6152 (TTY: 711)번으로 전화해 주십시오.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-844-859-6152 (TTY: 711).

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-844-859-6152 (टिटिवाइ: (TTY: 711) ।

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-859-6152 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-859-6152 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-859-6152 (TTY: 711).

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-844-859-6152 (TTY: 711).