

To Enroll in Samaritan Advantage Health Plan, Please Provide the Following Information: PAGE 1

Please check the plan you want to enroll in:
 Conventional Plan \$33.50 per month
 Premier Plan \$67 per month
 Premier Plan Plus \$78 per month

LAST Name: _____ FIRST Name: _____ Middle Initial: _____
 Mr. Mrs. Ms.

Birth Date: (__ / __ / ____) Sex: M F Social Security Number (providing this information is optional): _____ Home Phone Number: () _____

Permanent Residence Street Address: _____

City: _____ County (Residence): _____ State: _____ Zip Code: _____

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

Emergency contact (optional): _____ Relationship to You: _____ Phone Number: () _____

Primary Care Provider (PCP): _____

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 do not change your prescription drug coverage. However, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods. **Please read the following statement(s) and check the box to the left of the statements and we will contact you for additional information.** If none of these statements applies to you or if you are not sure, please contact us to see if you are eligible to enroll.

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| <ul style="list-style-type: none"> <input type="checkbox"/> I am new to Medicare. <input type="checkbox"/> I recently moved outside of the service area for my current plan. <input type="checkbox"/> I have both Medicare and Medicaid or my state helps pay for my Medicare Premiums. <input type="checkbox"/> I receive extra help paying for Medicare prescription drug coverage. <input type="checkbox"/> I live in a Long Term Care Facility (for example, a nursing home or long term care facility). <input type="checkbox"/> I recently moved "out" of a Long Term Care Facility (for example, a nursing home or long term care facility). <input type="checkbox"/> I recently "left" a PACE program. | <ul style="list-style-type: none"> <input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). <input type="checkbox"/> I am either losing coverage I had from an employer or union or leaving employer or union coverage. <input type="checkbox"/> I belong to a pharmacy assistance program provided by my state. <input type="checkbox"/> I recently returned to the United States after living permanently outside of the U.S. <input type="checkbox"/> I am no longer eligible for extra help paying for my Medicare prescription drugs. <input type="checkbox"/> I am enrolled in the Original Medicare Plan. |
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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.

MEDICARE HEALTH INSURANCE

Name: _____
 Medicare Claim Number: _____ Sex: _____
 _____ - _____ - _____
 Is Entitled To: _____ Effective Date: _____
 HOSPITAL (Part A) _____
 MEDICAL (Part B) _____

Office Use Only:
 Name of staff member (if assisted in enrollment): _____ Plan ID # _____
 Effective Date of Coverage: _____
 ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type:) _____ Not Eligible: _____

Paying Your Plan Premium:

You can pay your monthly plan premium by mail or Electronic Funds Transfer each month. You can also choose to pay your premium by automatic deduction from your Social Security Check each month. 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 does not cover. If you don't select a payment option, you will receive a bill each month. Please select a premium payment option:

- Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:
 Account holder name: _____ Account type: Checking Savings
 Bank Routing Number: _____ Bank account number: _____
- Receive a bill monthly.
- 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.)

Please read and answer these important 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 any more, 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 individual 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 Samaritan Advantage Health 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 facility, such as a nursing home?** Yes No
 If "yes" please provide the following information. Name of Institution: _____
 Address & Phone Number of Institution (Number & Street): _____

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| <p>4. Are you enrolled in your State Medicaid program? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", please provide your Medicaid number: _____</p> | <p>5. Do you or your spouse work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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6. **Since you became eligible for Medicare, have you had any prescription drug coverage or any insurance that included drugs?** Yes No
 If you answer "no", your premium may be increased because of a late enrollment penalty. If you answer "yes", we may ask you for proof that your previous prescription drug coverage was at least as good as Medicare's standard prescription drug coverage (creditable prescription drug coverage). You can send copies of your proof with this form or you can wait until we ask for it. You don't have to send your proof to enroll. However, if we ask for your proof and you don't provide it, your premium may be increased because of a late enrollment penalty. For more information about the late enrollment penalty, visit www.medicare.gov, or call 1-800-MEDICARE.

PLEASE READ PAGE 3 OF THIS DOCUMENT AND SIGN BELOW:

I understand that my signature on this application certifies that I have read and understand the contents of this application, including the statements on the back of this page.

Your Signature: X _____ **Today's Date:** _____

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

Name: _____ Phone #: _____
Address: _____ Relationship to Enrollee: _____

STOP! Please Read This Important Information:

If you currently have health coverage from an employer or union, joining Samaritan Advantage Health Plan could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Samaritan Advantage Health 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.

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

Samaritan Advantage Health Plan is a Medicare Advantage plan and I will need to keep my Medicare Parts A and B Insurance. 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 usually 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 Samaritan Advantage Health Plan or by calling 1-800-Medicare (TTY users should call 1-877-486-2048), 24 hours a day/7 days a week.

Samaritan Advantage Health Plan serves a specific service area. If I move out of the area that Samaritan Advantage Health 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 Samaritan Advantage Health Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Samaritan Advantage Health 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 Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Samaritan Advantage Health Plan coverage begins I must get all of my health care from Samaritan Advantage Health 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 Samaritan Advantage Health Plan and other services contained in my Samaritan Advantage Health Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR SAMARITAN ADVANTAGE HEALTH PLAN 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 health care operations. I also acknowledge that Samaritan Advantage Health 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 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 Samaritan Advantage Health Plan or by Medicare.

Notice:

If the person discussing plan options with you is either employed by or contracted with Samaritan Advantage Health Plan, that person may be compensated based on your enrollment in a Samaritan Advantage plan.

**Samaritan Health Plans**

Visit us: Monday–Friday, 8:30 a.m. to 5 p.m., 815 NW 9th Street, Corvallis, Oregon

Mailing Address: P.O. Box M, Corvallis OR 97339

Call us 8 a.m. to 8 p.m.: (541) 768-4550, 1-800-317-7489 (TTY 1-800-735-2900)