

INDIVIDUAL ENROLLMENT NON-GROUP ELECTION FORM

Please contact AmeriHealth 65® NJ HMO if you need information in another language or format (Braille).

A To Enroll in AmeriHealth 65 NJ HMO, Please Provide the Following Information:

Please check which plan you wish to enroll in:

AmeriHealth 65 NJ HMO Plan	Monthly Premium
<input type="checkbox"/> Medical Only (No Rx) (027)	\$145.00
<input type="checkbox"/> Rx (028)	\$191.60

LAST Name:	FIRST Name:	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date:	Sex:	Home Phone Number:
<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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

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

Street Address: _____

City: _____ State: ZIP Code:

Emergency Contact: _____

Phone Number: -- Relationship to You: _____


E-mail Address: _____

B 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) --

Attestation of Eligibility for an Enrollment Period

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 recently moved and this plan is a new option for me.
- 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 AmeriHealth 65® NJ HMO at 1-800-898-3492 (TTY users should call toll-free 1-877-219-5457) to see if you are eligible to enroll. We are open seven days a week, 8 a.m. to 8 p.m.**



Please Read This Important Information

If you currently have health coverage from an employer or union, joining AmeriHealth 65 NJ HMO could affect your employer or union health benefits. You could lose your employer or union health coverage if you join AmeriHealth 65 NJ HMO. 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.

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

AmeriHealth 65®NJ HMO 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. 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 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.

AmeriHealth 65 NJ HMO serves a specific service area. If I move out of the area that AmeriHealth 65 NJ HMO 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 AmeriHealth 65 NJ HMO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from AmeriHealth 65 NJ HMO 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 AmeriHealth 65 NJ HMO coverage begins, I must get all of my health care from AmeriHealth 65 NJ HMO, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by AmeriHealth 65 NJ HMO and other services contained in my AmeriHealth 65 NJ HMO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR AMERIHEALTH 65 NJ HMO 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 AmeriHealth 65 NJ HMO, he/she may be paid based on my enrollment in AmeriHealth 65 NJ HMO.

Release of Information: By joining this Medicare health plan, I acknowledge that AmeriHealth 65 NJ HMO will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that AmeriHealth 65 NJ HMO 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 AmeriHealth 65 NJ HMO or by 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: _____

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