AmeriHealth 65 HMO
A Medicare Advantage Plan from AmeriHealth HMO, Inc.

2011 Benefits & Information Change Form

Name:	**Member No.:**
Home Phone Number:	
Permanent Street Address: Street Address: City: State: ZIP Code:	
Mailing Address (only if different from your Permanent Street Address): Street Address: City: State: ZIP Code:	
Choose **ONE** of the 2 plans below by placing a check mark ✔ in the box ❑. For more information on coinsurance, copayments, deductibles, and limitations for each plan, see your Summary of Benefits and/or Evidence of Coverage.	
❑ AmeriHealth 65 NJ Medical-Only HMO	$160.70
❑ AmeriHealth 65 NJ Rx HMO	$216.10
Name of chosen Primary Care Physician (PCP), clinic or health center:	**Physician Code No.:**

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:

❑ Other language (please specify): ______________________ ❑ Braille or audio tape

Please contact AmeriHealth 65 NJ HMO at 1-800-645-3965 if you need information in another format or language than what is listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. TTY users should call 1-888-857-4816.

Your Plan Premium

You can pay your monthly plan premium by mail or ZipCheck® (Electronic Funds Transfer) each month. You can also choose to pay your premium by automatic deduction from your Social Security Check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, 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 won't have a coverage gap or a late enrollment penalty. Many people qualify 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 for this benefit. 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.

Y0041_HM11_16 CMS Approved 09022010 10435 (2010-0168) 09/10

Please select a premium payment option: ❑ Receive a bill ❑ Pay directly on ibxpress.com

❑ ZipCheck from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: ______________________________

Bank routing number: ☐☐☐☐☐☐☐☐☐

Bank account number: ☐☐☐☐☐☐☐☐☐☐☐☐

Account type: ❑ Checking ❑ Saving

❑ Automatic deduction from the monthly SSA benefit check. (The SSA deduction may take two or more months to begin. In most cases, the first deduction from the SSA benefit check will include all premiums due from the enrollment effective date up to the point withholding begins.)

Please Read This Important Information.

Please Read and Sign Below:

AmeriHealth 65 NJ HMO is a plan that has a contract with the Federal government.

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 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 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 people with Medicare aren't 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.**

By joining this plan, I confirm that I am not getting any financial support from my current or former employer group or union (or my spouse's current or former employer group or union)to buy medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage plan or Medicare Drug 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: _______ AEP: _______ SEP (type): _______ Not Eligible: _______