FirstMedicareDirect
FIRSTCAROLINACARE INSURANCE COMPANY

2019 Medicare Advantage Prescription Drug Plan (MAPD) Individual Enrollment Form

Please contact ***FirstMedicare Direct*** if you need information in another language or format (Braille or Large Print).

To Enroll in FirstMedicare Direct Please Provide the Following Information:

Please check which plan you want to enroll in:

☐ Healthy State HMO Plus (HMO) $42.00 per month

☐ Healthy State HMO Prime (HMO) $0 per month

LAST Name:	FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: / / MM / DD / YYYY	Sex: ☐ M ☐ F	Home Phone Number: (____)_____-_____	Alternate Phone Number: (____)_____-_____

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

City:	County:	State:	ZIP Code:
	□ Buncombe □ Madison □ Transylvania □ Henderson □ McDowell □ Yancey		

Mailing Address (Only if different from your Permanent Residence Address)

Street Address:	City:	State:	ZIP Code:

E-mail Address:

Emergency Contact:

Phone Number:	Relationship to You:

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled To: Effective Date:

HOSPITAL (Part A)

MEDICAL (Part B)

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

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, Electronic Funds Transfer (EFT), or credit card 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 FirstMedicare Direct the Part D-IRMAA.

People with limited incomes may qualify for *Extra Help* to pay for their prescription drug costs. If you 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 (monthly) in the mail ☐ Electronic Funds Transfer (EFT) ☐Credit Card

NOTE: If you select Electronic Funds Transfer (EFT) or Credit Card, you will receive information about how to provide your banking/credit card information securely.

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

I get monthly benefits from: ☐ Social Security ☐ RRB

(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 FirstMedicare Direct?

☐ 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:

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

☐ Braille ☐ Large print

Please contact FirstMedicare Direct at 844-201-4957 if you need information in an accessible format or language other than what is listed above. Our Member Service hours are 8 a.m. to 8 p.m. Eastern seven days a week from October 1, 2018, through March 31, 2019. Beginning April 1, 2019, through September 30, 2019 our customer service hours are 8 a.m. to 8 p.m. Eastern, Monday through Friday. Persons with hearing impairments please call TTY at 711.

Please Read This Important Information

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

FirstMedicare Direct 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.

FirstMedicare Direct serves a specific service area. If I move out of the area that FirstMedicare Direct 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 FirstMedicare Direct, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from FirstMedicare Direct 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.

HMO Applicants: I understand that beginning on the date FirstMedicare Direct coverage begins, I must get all of my health care from FirstMedicare Direct Medicare, except for emergency or urgently needed services or out-of-area dialysis services.

Without authorization, **NEITHER MEDICARE NOR FIRSTMEDICARE DIRECT 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 FirstMedicare Direct, he/she may be paid based on my enrollment in FirstMedicare Direct.

Release of Information: By joining this Medicare health plan, I acknowledge that FirstMedicare Direct will release my information to Medicare and other plans or providers as is necessary for treatment, payment and health care operations. I also acknowledge that FirstMedicare Direct 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 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: Plan ID# (Contract/Plan#):_____-____ Effective Date: Mo.__ Yr. ___**2019**_____

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

Agent No.:_____

ICEP/IEP ☐ AEP ☐ SEP ☐ (type):_____Not eligible:___

Notes:

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage Plan outside of this period.

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 am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).*

☐ 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 was released from incarceration. I was released on (insert date):_____

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date): _____

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date): _____

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ 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.
☐ My plan is ending its contract with Medicare or Medicare is ending its contract with my plan.
☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.
☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date):
☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact FirstMedicare Direct at 877-279-1732 (TTY users should call 711) to see if you are eligible to enroll. Member Service is available from October 1, 2018 through March 31, 2019 from 8 a.m. to 8 p.m. Eastern seven days a week. Beginning April 1, 2019, through September 30, 2019, we are open from 8 a.m. to 8 p.m. Eastern Monday through Friday. FirstCarolinaCare Insurance Company complies with federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak a language other than English, assistance services, free of charge, are available to you. Call 1-844-201-4957 (TTY 711). ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-201-4957 (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 1-844-201-4957（TTY 711)。