



UNIVERSAL ENROLLMENT FORM FOR MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN (MA-PD) (FOR THOSE ENROLLED IN MEDICARE PART A AND PART B)

INSTRUCTIONS

Print your name and Social Security number at the top of the second and third pages.

PAGE 1 – CARRIER-REQUIRED INFORMATION SECTION I: PERSONAL INFORMATION

- Fill in the personal information requested. If you and your spouse are both enrolling, complete two separate forms. With the exception of a spouse, please disregard any requests for dependent information on the form.

PAGE 2 – CARRIER-REQUIRED INFORMATION SECTION II: MEDICAL INFORMATION

- Please answer the four questions by checking “Yes” or “No” on the right-hand side of the form.
- Answer for member and, if enrolling, for spouse/survivor.

SECTION III: BINDING ARBITRATION AGREEMENT

- Carefully read each paragraph in this section and the “Statement of Understanding” and “Authorization to Exchange Information” on the back of this form and the Binding Arbitration Agreement in Section III.
- Sign and date the form at the bottom on the lines provided in this section.
- If someone has assisted you in completing this form, that person must also sign this form and indicate his/her relationship to you.
- If a person with Durable Power of Attorney for Health Care (DPAHC) or another legal representative (as defined by State law) has helped you complete this form, they must sign and attach certificate or other written proof of guardianship.

PAGE 3 – LACERA-REQUIRED INFORMATION SECTION IV: MEDICAL PLAN

- Check those who have completed the form and provide information requested.
- Check LACERA member’s marital status.
- Check the box next to the MA-PD plan in which you wish to enroll.
- Next, write in the name and facility number of the contracting medical group or physician that you have selected. Refer to your plan’s Provider Directory for medical group and physician information.
- Fill in your Medicare information on the replica of the Medicare card or attach a photocopy of your Medicare card.

SECTION V: LACERA AUTHORIZATION

- Carefully read each paragraph and the “Statement of Understanding” on the back of this form. Initial where appropriate in the space provided in Section V.
- Sign and date the form on the lines provided in this section.
- If someone has assisted you in completing this form, that person must also sign this form and indicate his/her relationship to you.
- If a person with Durable Power of Attorney for Health Care (DPAHC) or other legal representative (as defined by State law) has helped you complete this form, they must sign and attach certificate or other written proof of guardianship.

Note: The arbitration agreement at the bottom of the “Statement of Understanding” does not pertain to Nevada residents.

MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN (MA-PD) UNIVERSAL ENROLLMENT FORM

SECTION I: Personal Information					
Medicare Advantage Prescription Drug (MA-PD) plan you are requesting enrollment in:					
Group Name (required) LACERA		Account#		Requested Effective Date <i>(for office use only)</i>	
Desired Contracting Medical Group		Desired Contracting Physician		Medical Group/Physician No.	
Last Name (Print)		First Name (Print)		M.I.	Social Security Number (optional)
Permanent Residence Address (No P.O. box)		City	State	Zip Code	County
Mailing Address (if different)		City	State	Zip Code	
Telephone Number (including area code) ()		Birth Date			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Are you currently a member of an MA-PD plan? (Your response to this question is optional.) <input type="checkbox"/> Yes <input type="checkbox"/> No If so, which one?					
Part A Effective Date		Part B Effective Date		Health Insurance Claim No. (HIC)	
Spouse	Name (Last, First, M.I.)		Birth Date		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Health Insurance Claim No.	Part A Effective Date	Part B Effective Date	Social Security Number (optional)	
Dependent	Name (Last, First, M.I.)		Birth Date		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Health Insurance Claim No.	Part A Effective Date	Part B Effective Date	Social Security Number (optional)	

Distribution: White = Health Plan Copy Pink = Member Copy



Last Name (Print) _____ First Name (Print) _____ M.I. _____ Social Security Number _____

(To Be Filled out by LACERA)

Retirement Date: _____
Effective Date: _____
 SCD NSCD

Years of Services: _____
Deduction Code: _____
Premium: _____

Please check all that apply:
Completed by Retiree Enter retirement date: _____
 Spouse Enter name of retiree: _____
 Survivor Enter name of retiree: _____

Marital Status:
 Single Married,
 Widowed If yes Date
 Divorced of Marriage _____

SECTION IV: Medical Plan

I wish to enroll in the following MA-PD plan: (Check one and fill in the requested information. Refer to *your* plan's Provider Directory for physician/medical group selections.)

Kaiser Senior Advantage

Please check the state in which you live:
 CA CO GA HI OR

If you were ever a Kaiser member when you were under age 65, please list your medical record number _____

CIGNA HealthCare for Seniors--(only in Phoenix, Arizona)

PacifiCare/Secure Horizons

If you were ever a PacifiCare member when you were under age 65, please include your member number _____
Provider preference. Please specify your selection below:

Physician Name _____ Number _____

Medical Group _____ Number _____

SCAN (Senior Care Action Network)

1. _____ I understand that SCAN Health Plan is an MA-PD Plan program operating under contracts with CMS (Initials) and the State of California. In the event the program is not continued, SCAN Health Plan must assist me in obtaining suitable alternative health care and provision of my Medicare-covered health care will not be interrupted.

2. Provider preference. Please specify your selection below:

Physician Name _____ Number _____ Hospital Name _____ Number _____

IPA/Group _____ Number _____ Dentist Name _____ Number _____

On the replica of the Medicare card shown (below), please fill in your personal information as it appears on the Medicare Health Insurance card. If you prefer, you may include a photocopy of your Medicare card or a copy of your Medicare verification letter, instead.

This enrollment form will not be complete until we have obtained this information. It is required to process your enrollment.

SECTION V: LACERA Authorization

I understand the LACERA Board of Retirement reserves the right to amend, revise or discontinue these plans and programs at any time. I hereby enroll in the MA-PD HMO indicated above. I authorize the Los Angeles County Employees Retirement Association (LACERA) to make the necessary deductions from my retirement warrants for any contributions required of me and to send these contributions to the MA-PD HMO I have chosen.

(Initials) *Please read the information on the back of this form and initial here before signing. If you submit this form without initialing it, this form will be considered incomplete and the start of your coverage may be delayed.*

Your signature or signature of guardian, conservator or power of attorney* Date

**If this is being submitted by a guardian, conservator, or person with power of attorney, please attach the legal documents establishing guardianship, conservatorship or power of attorney.*

If anyone helped you fill out any portion of this form, with the exception of the effective date, please have them sign the following:

Signature Date Relationship to Individual

STATEMENT OF UNDERSTANDING

Please read each of the statements that follow before signing this form:

I understand that Medicare Advantage plans are contracted with the Federal government and I will abide by any Health Plan policies and rules that may apply to me.

- Lock-In: I understand that, beginning on the date of my Medicare Advantage Prescription Drug plan coverage begins, I must get all of my health care from/through the Medicare Advantage Prescription Drug plan, with the exception of emergency and out-of-area urgently needed services, dialysis services or authorized referrals. I understand that services authorized by the Medicare Advantage Prescription Drug plan and other services contained in my plan *Evidence of Coverage* document will be covered. I also understand that without authorization neither Medicare nor the Medicare Advantage Prescription Drug plan will pay for the services. As a Medicare Advantage Prescription Drug plan member, I understand that I am bound by the benefits, copayments, exclusions, limitations, and other terms of the Medicare Advantage Prescription Drug plan *Evidence of Coverage*.
- I understand that I will be notified by mail of the final confirmation of my enrollment in the plan and the effective date of my coverage. I understand that I should not disenroll from any supplemental plan until my enrollment is confirmed.
- I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premium and the Part A premium, if applicable.
- I understand that I can be a member of only one Medicare Advantage Prescription Drug plan at a time. By enrolling in the Medicare Advantage Prescription Drug plan specified on this form, I understand that I will be automatically disenrolled from any other Medicare Advantage Prescription Drug plan of which I am currently a member.
- I also understand that since I can be a member of only one Medicare Advantage Prescription Drug plan at a time, I cannot enroll in more than one Medicare Advantage Prescription Drug plan with the same effective date of coverage. If I do this, my enrollments will be canceled and I will have to fill out a new enrollment form to become a member of a Medicare Advantage 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 I may request termination of this Medicare Advantage Prescription Drug plan at any time by sending a written request for disenrollment to the health plan, the Social Security Administration or the Railroad Retirement Board or by calling **1-800-MEDICARE (1-800-633-4227)**. Until the effective date of disenrollment, I must continue to receive health care from my current plan providers.
- I understand that if I do not 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.

- I understand that it is my responsibility to inform the Medicare Advantage Prescription Drug plan before permanently moving (for 6 months or longer) out of the service area or a continuation area, if applicable to your plan. I understand that if I move permanently out of the service area or continuation area, Medicare requires the Medicare Advantage Prescription Drug plan to disenroll me.
- I understand that if I disenroll from the LACERA-administered Medicare Advantage Prescription Drug plan, I may be automatically transferred to the Original Medicare plan (fee-for-service program). I understand that if I choose to enroll in a non-LACERA-administered Medicare Advantage Prescription Drug plan, or another employer-sponsored Medicare Advantage Prescription Drug plan, I will be automatically disenrolled from this LACERA-administered health plan.
- I understand that, as a member of the Medicare Advantage Prescription Drug plan, I have the right to appeal service and payment denials made by the plan.

AUTHORIZATION TO EXCHANGE INFORMATION

Please read the following statements before you sign this form.

- I hereby authorize the Centers for Medicare & Medicaid Services to furnish information to the health plan confirming my Part A (hospital) and Part B (medical) Medicare entitlement, and if my enrollment is terminated, the effective date of my termination.
- I hereby authorize the health plan, or any holder of medical information about me including, but not limited to, physicians, hospitals, insurance companies, and other organizations, to release any information in the course of examination or treatment of myself, which is relevant to the provision of or the coordination of benefits or professional review activities. I also acknowledge that my health plan may release my information to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this election 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 also authorize the health plan, or any holder of medical information about me including, but not limited to, physicians, hospitals, insurance companies, and other organizations, to release to the Centers for Medicare & Medicaid Services or its intermediaries or carriers, any information needed to administer Title XVIII (the Medicare section) of the Social Security Act.

LACERA treats your and your family's personal health information as confidential. We follow the applicable sections of HIPAA related to privacy and security of your protected health information. If you have any questions about the steps taken to secure your protected health information, please refer to the HIPAA policy posted on the LACERA website at www.lacera.com.

NOTE: YOU MUST INITIAL THE AREA IN SECTION V: LACERA Authorization STATING YOU HAVE READ THE ABOVE STATEMENT OF UNDERSTANDING AND AUTHORIZATION TO EXCHANGE INFORMATION. IF YOU SUBMIT THIS FORM WITHOUT INITIALING IT, THIS FORM WILL BE CONSIDERED INCOMPLETE AND THE START OF YOUR COVERAGE MAY BE DELAYED.