# Preferred Gold/GoldAnywhere Enrollment Application & Part D Application
## EMPLOYER GROUP

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

MVP is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my 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. I also understand that if I enroll in a stand-alone Prescription Drug Plan (PDP), I will automatically be disenrolled from Preferred Gold or GoldAnywhere and transferred to the Original Medicare Plan (fee-for-service program)**.

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 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. 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: Annual enrollment period from November 15 – December 31), or under certain special circumstances.

MVP Health Plan, Inc. serves a specific service area. If I move out of the area that MVP 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 MVP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage (contract) from MVP 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 MVP coverage begins, I must get all of my health care from MVP, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by MVP and other services contained in my MVP Evidence of Coverage document (also know as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MVP WILL PAY FOR THE SERVICES.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with MVP, he/she may be compensated based on my enrollment in MVP.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

**Please complete all three pages.**
**Complete one enrollment form per applicant.**

## Section 1: Plan Enrollment Selection for Employer Group or Union Members

Employer or union providing coverage ________________________ Group # ____________

Select Plan:

- ☐ Preferred Gold with MVP Part D Prescription Drug
- ☐ Preferred Gold without MVP Part D Prescription Drug
- ☐ GoldAnywhere with MVP Part D Prescription Drug
- ☐ GoldAnywhere without MVP Part D Prescription Drug

## Section 2: Member Information

Last Name ________________________ First Name ____________________ Mid. Init. ______

Social Security # ☐☐☐-☐☐-☐☐☐☐

Permanent Resident Address *(include number, street, and apt. #)* ____________________________

City ________________________ State ______ ZIP Code ______ County ____________

Telephone Number ( ) ______ - ______ Date of Birth ____ / ____ / ____ Gender: ☐ Male ☐ Female

Mailing Address (*if different from permanent address — include number, street, and apt. #)* ________________

________________________________________________________________

City ____________________ State ______ ZIP Code ________ County ______________

## Section 3: Medicare Card 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 # ☐☐☐-☐☐-☐☐☐☐ ☐

Is Entitled To: Hospital (Part A) ____ / ____ / ____

Medical (Part B) ____ / ____ / ____

## Section 4: Primary Care Physician (PCP)

________________________________________________________________

Primary Care Physician *(full name required)*

________________________________________________________________

Address

Existing patient? ☐ Yes ☐ No

## Section 5: Please read and answer the following questions

1. Are you the retiree? ☐ Yes ☐ No

   If yes, retirement date *(month/day/year)* ____________ If no, name of retiree ________________________

2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No

   If yes, name of spouse ________________________________________________

   Names of dependents ________________________________________________

3. Do you or your spouse work? ☐ Yes ☐ No

4. 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.

5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs (EPIC).

   Will you have other prescription drug coverage in addition to MVP? ☐ Yes ☐ No

   If yes, name of other coverage ________________________________________________

   ID # ________________________ Group # ________________________

**Your answer to the following questions will not keep you from enrolling in this plan.**

6. 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): ________________________

   ________________________________________________

7. Do you have existing Part D Prescription Drug Coverage. ☐ Yes ☐ No

   If yes, what was the effective date of your existing coverage?

   ☐ The day I became eligible for Medicare

   ☐ January 1, 2006,

   ☐ Other (enter date) ________________

8. Since you became eligible for Medicare, have you had any prescription drug coverage or any insurance that included drugs other than Part D? ☐ Yes ☐ No

## Section 6: Signature and Authorization

**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 MVP 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 MVP or by Medicare.

**PLEASE SIGN BELOW**

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 ______________________

**For Office Use Only**

**Enter in:**

☐ **Amisys**

☐ **Facets**

If current member, please include member ID number:

A

OR

800

Previous ID # ______________ Group Name ______________ Group # ______________

Effective Date ______________ Input Date ______________ Initials ______________

☐ ICEP/IEP ☐ OEP ☐ AEP ☐ SEP (type): ______________ Not eligible: ______________

Date coverage should begin: ______/______/ ______ **(employer group use only)**

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

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