

Please contact First Plus if you need information in another language or format. **PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION**

To enroll in First+Plus Complete (HMO_SNP), please provide the following information:

Please check which plan you want to enroll in: ____ First Plus Complete (HMO_SNP)

Sex:	<input type="checkbox"/> Mr.	LAST name:	FIRST name:	Middle Initial	Date of Birth
<input type="checkbox"/> M	<input type="checkbox"/> Mrs.				
<input type="checkbox"/> F	<input type="checkbox"/> Miss.				

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

City	State	Zip Code	Home Phone Number
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Mailing Address (only if different from your Permanent Residence Address):

Street Address : _____ City: _____ State: _____ Zip Code: _____

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 or the Railroad Retirement Board

You Must Have Medicare part A and Part B to join a Medicare Advantage Plan



Name: _____

Medicare Claim Number _____ Sex _____
 ____ - ____ - ____

Is Entitled To Hospital (Part A) _____ Effective Date _____
 Medical (Part B) _____

Please read and answer these important question

1. Some individuals may have other drug coverage, including 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 First+Plus? YES ____ NO ____
 If "yes", please list your coverage and your identification (ID) number(s) for this coverage:
 Name of other coverage: _____ ID# for this coverage _____ Group # for this coverage _____

4. Please Choose the name of a Primary Care Physician (PCP, clinic or health center):
 Name: _____
 Phone: _____

2. 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) _____

5. Do you have diabetes? YES ____ NO ____

3. Do you have End Stage Renal Disease (ESRD)? YES ____ NO ____
 If you answered "yes" to this question and you don't need regular dialysis any more, or have had a successful kidney transplant, please attach a note or record from your doctor showing you do not need dialysis or have had a successful kidney transplant.

6. Do you or your spouse work? YES ____ NO ____

7. Are you enrolled in your State Medicaid program? YES ____ NO ____
 If yes, please provide your Medicaid number: _____

Please check one of the boxes below if you would prefer that we send you information in a language other than Spanish or other format:
 ____ English ____ Please specify format: _____
 Please contact First Plus at 1-877-662-4242 if you need information in another format or language that what is listed above. Our offices hours are Monday to Friday 8:00am to 5:30pm. TTY users should call 1-877-672-4242.

Please Read at back of the application and Sign Below

Signature: _____ **Today's Date** _____

If you are the authorized representative, you must sign above and provide the following information
Name: _____ **Relationship to Enrollee** _____
Phone Number: (____) ____ - _____

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:** ____

Paying Your Plan Premium

If we determine that you owe a late enrollment penalty, we need to know how you 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 benefit check each month.

_____ Get a coupon book _____ Electronic Funds Transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account Holder Name: _____ Bank Routing Number: _____ Bank Account Number: _____

_____ Credit Card. Please provide the following information: Type of Card: _____ Name of Account Holder as it appears on card: _____

Account Number: _____ Expiration Date: _____

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

STOP Please Read This Important Information

If you have health coverage from an employer or union, joining First+Plus could affect your employer or union health benefits. You could lose your employer or union health coverage if you join First+Plus. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communication. If there isn't any information on whom to contact, your benefits administrator or the office that answers question about your coverage can help.

Please Read

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

First+Plus 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 another Medicare health 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 if the year if an enrollment period is available (Example: Annual Enrollment Period from November 15 – December 31), or under certain special circumstances.

First+Plus serves a specific service area. If I move out of the area that First+Plus 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 First+Plus, I have the right to appeal plan decision about payment or services if I disagree. I will read the Evidence of Coverage document from First+Plus when I provides services in a specific area. If I move out of the area in which First +Plus provides services, I need to notify the plan of this information so that I may disenroll and get another plan in my area. Once affiliated to First +Plus, I have the right to appeal the decision of the plan in regards to payments or services that I am not in agreement with. I will read the Evidence of Coverage of First +Plus 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 U.S. border.

I understand that beginning on the date First+Plus coverage begins, I must get all of my health care from First+Plus , the effective date of my coverage with First +Plus, I must obtain all my health care with providers of First+Plus, except for emergency services or urgently needed services or out-of-area dialysis services. Services authorized by First+Plus and other services contained in my First Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization. NEITHER MEDICARE NOR FIRST+PLUS 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 First+Plus, he/she may be paid based on my enrollment in First+Plus. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.

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 First+Plus will release my information including my prescription drug even data to Medicare, who may release it for research and other purpose 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 First+Plus or by Medicare

