


Please contact First+Plus (PPO) if you need information in another language or format.				PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION			
To enroll in First+Plus (PPO), please provide the following information:				Please take out your Medicare Card to complete this section <input type="radio"/> Please fill in these blanks so they match your red, white and blue Medicare card -OR- <input type="radio"/> 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		MEDICARE  HEALTH INSURANCE	
Please check which plan you want to enroll in: ___ Advantage (PPO)\$0 ___ Advantage Plus (PPO)\$0 ___ Advantage Premium (PPO) \$20						Name: _____	
Sex:	<input type="checkbox"/> Mr.	LAST name:	FIRST name:	Middle Initial	Date of Birth	Medicare Claim Number _____ Sex _____	
<input type="checkbox"/> M	<input type="checkbox"/> Mrs.					_____ - _____ - _____	
<input type="checkbox"/> F	<input type="checkbox"/> Miss.					Is Entitled To _____ Effective Date _____	
						Hospital (Part A) _____ Medical (Part B) _____	
Permanent Residence Street Address (P.O. Box is not allowed)							
City		State	Zip Code	Home Phone Number			
Mailing Address (only if different from your Permanent Residence Address):							
Street Address :		City:	State:	Zip Code:			
Please read and answer these important question							
1. 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				4. 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) _____			
2. 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 ___			
3. 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 <u>prescription</u> 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 _____							
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 8:00pm. 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. You can pay your monthly plan premium 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 each month. If you don't select a payment option, you will get a coupon book each month. Please select premium payment option:

_____ 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.)

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