


Please contact First+Plus if you need information in another language or format.				PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION				
To enroll in First +Plus Gobierno UPR, please provide the following 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 or the Railroad Retirement Board You Must Have Medicare part A and Part B to join a Medicare Advantage Plan				
Employer or Union Group: ____ UPR Retirement		# Group _____				Name: _____		
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss.	LAST name: _____	FIRST name: _____			Middle Initial _____	Date of Birth _____	Medicare Claim Number _____ Sex _____
Permanent Residence Street Address (P.O. Box is not allowed)						Is Entitled To _____ Effective Date _____		
City _____		State _____	Zip Code _____	Home Phone Number _____		Hospital (Part A) _____ Medical (Part B) _____		
Mailing Address (only if different from your Permanent Residence Address): Street Address : _____				City: _____		State: _____ Zip Code: _____		
Please read and answer these important questions								
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. Some individuals may have other drug coverage, including private insurance, Worker's Compensation, 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 _____				
2. Are you covering a spouse or dependents under this employer or union plan? YES ____ NO ____ If yes, name of spouse : _____ Name of Dependents _____				5. 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) _____				
3. ¿Do you or your spouse work? YES ____ NO ____				6. Are you retiree? YES ____ NO ____ If yes, retirement date (month/date/year): _____.				
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: <input type="checkbox"/> 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: ____				

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

