



**SECURECARE
EMPLOYER GROUP
ENROLLMENT FORM**

Ohio Valley Region
52160 National Road East
St. Clairsville, Ohio 43950-9365
Telephone: (740) 695-7915
Toll Free 1-877-847-7915
Hearing Impaired 1-800-622-3925
www.healthplan.org

Mountaineer Region
1137 VanVoorhis Road
Chelsea Square, Suite 44
Morgantown, WV 26505
Toll Free: 1-877-598-3910
Hearing Impaired 1-800-622-3925

HomeTown Region
100 Lillian Gish Blvd.
P.O. Box 4816
Massillon, OH 44648-4816
Toll Free: 1-877-236-2290
Hearing Impaired 1-877-236-2291

To Enroll in SecureCare, Please Provide the Following Information:

Employer or Union Name:			Group #:		
LAST name:		FIRST name:		Middle Initial	
				<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	
Birth Date:		Sex:		Social Security Number:	
(M M / D D / Y Y Y Y)		<input type="checkbox"/> M <input type="checkbox"/> F		(providing this information is optional) ()	
Home Phone Number: ()					
Permanent Residence Street Address:					
City:		State:		ZIP Code:	

Mailing Address: (only if different from your Permanent Residence Address):

Street Address: _____ City: _____ State: _____ ZIP Code: _____

Please Provide Your Medicare Insurance Information

<p>Please take out your Medicare Card to complete this section.</p> <ul style="list-style-type: none"> • 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. <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>	<p>Name: _____</p> <p>Medicare Claim Number _____ Sex _____</p> <p>_____ - _____ - _____</p> <p>Is Entitled To _____</p> <p style="text-align: right;">Effective Date _____</p> <p>HOSPITAL (Part A) _____</p> <p>MEDICAL (Part B) _____</p>
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Please read and answer these important questions:

1. Are you the retiree? Yes No

If yes, retirement date (month/date/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: _____

Name 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.

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

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____

ID # for this coverage: _____

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): _____

Please choose the name of a Primary Care Physician (PCP) _____

Please choose the name of a Secondary Care Physician (SCP) _____

Please choose the name of an Ob-Gyn Care Physician _____

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

_____ **Spanish**

_____ **Large Print**

Please contact us at 1-877-847-7915 (TTY users should call 1-800-622-3925) if you need information in another format or language than what is listed above. Our office hours are 8:00 am to 5:00 pm Monday through Friday.

Please Read and Sign Below:

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

SecureCare 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 only be in 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. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.

SecureCare serves a specific service area. If I move out of the area that SecureCare 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 SecureCare, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from The Health Plan 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 SecureCare coverage begins, I must get all of my health care from SecureCare, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by The Health Plan and other services contained in my SecureCare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE HEALTH PLAN 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 The Health Plan, he/she may be compensated based on my enrollment in SecureCare.

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.

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 The Health Plan will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which will 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 The Health Plan or by Medicare.

Your Signature: _____	Today's Date: _____
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If you are the authorized representative, you must sign above and provide the following information:

Name : _____

Address: _____

Phone Number: (____) ____ - ____ **Relationship to Enrollee** _____

Office use only

Name of staff member/agent/broker (if assisted in enrollment): _____ Rep Code: _____

Plan ID#: _____ Group #: _____

Effective Date of Coverage: _____ Date Received: _____

ICEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____