



**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](http://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

**SECURECARE HMO  
 ENROLLMENT FORM**

**To Enroll in SecureCare HMO, Please Provide the Following Information:**

Please check which plan you want to enroll in:

- |   |   |  |
|---|---|--|
| <p><b>Ohio Valley Region</b><br/> <input type="checkbox"/> \$0 per month<br/>         (No Prescription Coverage)<br/> <input type="checkbox"/> \$99 per month<br/>         (Includes Prescription Coverage)</p> | <p><b>Mountaineer Region</b><br/> <input type="checkbox"/> \$0 per month<br/>         (No Prescription Coverage)<br/> <input type="checkbox"/> \$99 per month<br/>         (Includes Prescription Coverage)</p> | <p><b>HomeTown Region</b><br/> <input type="checkbox"/> \$0 per month<br/>         (No Prescription Coverage)<br/> <input type="checkbox"/> \$99 per month<br/>         (Includes Prescription Coverage)</p> |
|---|---|--|

LAST Name:	FIRST Name:	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date: ( <u>  </u> / <u>  </u> / <u>  </u> <u>  </u> <u>  </u> <u>  </u> ) ( <u>  </u> <u>  </u> <u>  </u> / <u>  </u> <u>  </u> / <u>  </u> <u>  </u> <u>  </u> <u>  </u> <u>  </u> <u>  </u> )	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ( <u>  </u> )	Alternate Phone Number: ( <u>  </u> )
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Permanent Residence Street Address (P.O. Box is not allowed):

City:	State:	ZIP Code:
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Mailing Address: (only if different from your Permanent Residence Address):

Street Address:	City:	State:	ZIP Code:
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**Please Provide Your Medicare Insurance 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 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 \_\_\_\_\_ Effective Date \_\_\_\_\_

HOSPITAL (Part A) \_\_\_\_\_

MEDICAL (Part B) \_\_\_\_\_

## Paying Your Plan Premium

You can pay your monthly plan premium by mail or "Electronic Funds Transfer (EFT)" each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at [www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.gov/prescriptionhelp).

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get payment coupons.

Please select a premium payment option:

- Get payment coupons.
- Electronic Funds Transfer (EFT) from your bank account each month. Please enclose a VOIDED check along with a signed ACH Contract.
- 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 your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

### 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 if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant.

2. Some individuals may have other drug coverage, including other 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 SecureCare HMO?  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: \_\_\_\_\_

Group # for this coverage: \_\_\_\_\_

3. 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): \_\_\_\_\_

4. 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

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 a Ob-Gyn Care Physician \_\_\_\_\_

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**Please check below if you would prefer us to send you information in another format:**

\_\_\_\_\_ **Large Print**

**Please contact us at 1-877-847-7915 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. TTY users should call 1-800-622-3925.**



### Please Read This Important Information

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

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you don't add or drop your prescription drug coverage (i.e. if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage you can only change to another plan without Medicare prescription drug coverage). Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) \_\_\_\_\_.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) \_\_\_\_\_.

- I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) \_\_\_\_\_.
- I recently left a PACE program on (insert date) \_\_\_\_\_.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) \_\_\_\_\_.
- I am leaving employer or union coverage on (insert date) \_\_\_\_\_.
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the US. I returned to the U.S. on (insert date) \_\_\_\_\_.
- None of these statements apply to me. \*

Please contact us at 1-877-847-7915 (TTY users should call 1-800-622-3925) to see if you are eligible to enroll. We are open 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 HMO 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 in another Medicare health plan or prescription drug plan. 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 don't 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: November 15 - December 31 of every year), or under certain special circumstances.

SecureCare HMO serves a specific service area. If I move out of the area that SecureCare HMO 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 Health Plan SecureCare HMO, 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 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 the U.S. border.

I understand that beginning on the date Health Plan SecureCare HMO coverage begins, I must get all of my health care from The Health Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by The Health Plan and other services contained in my SecureCare HMO 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 getting assistance from a sales agent, broker or other individual employed by or contracted with The Health Plan, he/she may be paid 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 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 Health Plan SecureCare HMO 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 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 The Health Plan or by Medicare.

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 _____

<b>Office Use Only:</b>	
Name of staff member/agent/broker (if assisted in enrollment): _____	Rep Code: _____
Plan ID #: _____	Group # _____
Effective Date of Coverage: _____	
Date Received: _____	Check Number: _____
CheckAmount: _____	
ICEP/IEP: _____	OEP: _____
AEP: _____	SEP (type): _____
Not Eligible: _____	