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Springfield, MA 01144-1500
413.787.0010 · 877.443.3314
TTY/TDD 1.800.439.2370
hne.com/medicare

2016 CONNECTICUT INDIVIDUAL ENROLLMENT REQUEST FORM

Please contact HNE Medicare Advantage if you need information in another language or format (Braille).

To Enroll in an HNE Medicare Advantage Plan, Please Provide the Following Information:

Please check which plan you want to enroll in:

❒ HNE Premier 1 (HMO) - $0 per month

❒ HNE Premier 2 (HMO) - $87 per month

❒ HNE Premier 3 (HMO-POS) - $65 per month

LAST Name:	FIRST Name:	Middle Initial:	❒ Mr. ❒ Mrs. ❒ Ms.

Birth Date: (_____/ _____/_____) (MM/ DD/ YYYY	Sex: ❒ M ❒ F	Home Phone Number: ( )	Alternate Phone Number: ( )

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

City:	State:	ZIP Code:

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

Street Address: City: State: ZIP Code:

E-mail Address:

Please Provide Your Medicare Insurance Information

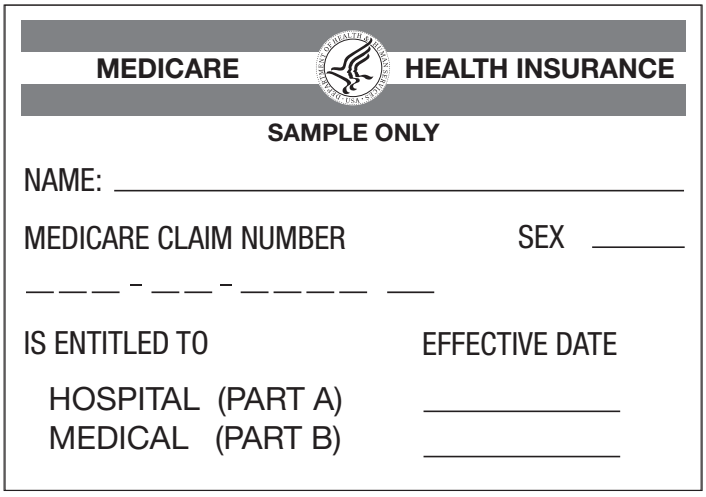
Please take out your Medicare card to complete this section.

- 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.


MEDICARE HEALTH INSURANCE

SAMPLE ONLY

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 (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld form your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay HNE Medicare Advantage the Part D-IRMAA.

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 800.772.1213. TTY users should call 800.325.0778. You can also apply for extra help online at 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 a bill each month.

Please select a premium payment option:

❒ Get a bill

❒ 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: _____

Account type: ❒ Checking ❒ Saving

❒ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD)? ❒ Yes ❒ No
   If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.
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 HNE Medicare Advantage Plan?
   ❒ 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 Provider (PCP): _____

PCP Provider ID # (Found in the Provider Directory): _____

Please check the box below if you would prefer us to send you information in another format:
❒ Large Print
Please contact HNE Medicare Advantage at 413.787.0010 or 877.443.3314 if you need information in another format or language than what is listed above. Our office hours are 8 a.m. - 8 p.m., seven days a week. (TTY users should call 800.439.2370.)

Please Read This Important Information

If you currently have health coverage from an employer or union, joining an HNE Medicare Advantage Plan could affect your employer or union health benefits. **You could lose your employer or union health coverage if you join an HNE Medicare Advantage Plan.** 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.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:
HNE Medicare Advantage 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 be in only 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: October 15 - December 7 of every year), or under certain special circumstances.

HNE Medicare Advantage Plans serve a specific service area. If I move out of the area that HNE Medicare Advantage Plans serve, 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 an HNE Medicare Advantage Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from the HNE Medicare Advantage 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 the HNE Medicare Advantage Plan coverage begins, I must get all of my health care from the HNE Medicare Advantage Plan, except for emergency or urgently needed services or out-of-area dialysis services. Members enrolled in our HNE Premier (HMO) and HNE Premier 2 (HMO) plans must use HNE network providers for all routine medical care. Members enrolled in our HNE Premier 3 (HMO-POS) plan can choose to get routine medical care from network providers or use their Point of Service benefit to get care from non-network providers. HNE Premier 3 members pay more when they use non-network providers for routine medical care. Some services require prior authorization. Our network providers know what we cover under your benefit plan. They also know what requires prior authorization and will request approval from HNE on your behalf. Members of the HNE Medicare Premier 3 (HMO-POS) plan who choose to get these services out-of-network are responsible for getting prior authorization from HNE. Please tell your out-of-network provider that prior authorization is required. The provider may be willing to contact HNE Member Services for you to get prior authorization. Call Member Services to confirm prior authorization. For a complete list of services that require prior authorization, refer to the Summary of Benefits. Services authorized by HNE Medicare Advantage and other services contained in my HNE Medicare Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE HNE MEDICARE ADVANTAGE 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 HNE Medicare Advantage Plans, he/she may be paid based on my enrollment in HNE Medicare Advantage Plans.

Release of Information: By joining this Medicare health plan, I acknowledge that the HNE Medicare Advantage 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 HNE Medicare Advantage 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 from Medicare.

Your 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: _____

Office Use Only:

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

Broker NPN#: _____

Plan ID #: _____

Effective Date of Coverage: _____

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

Please keep the colored copy for your records.