



Enrollment Form

PPO

To be eligible to enroll in PrimeTime Health Plan:

1. You must have Medicare Parts A and B.
2. You must live in the PrimeTime Health Plan service area.
(Carroll, Columbiana, Harrison, Holmes, Jefferson, Mahoning, Stark, Tuscarawas, and Wayne counties)
3. You cannot have End-Stage Renal Disease (ESRD) at the time of enrollment, unless you do not need regular dialysis or have had a successful kidney transplant.

Enrolling in PrimeTime Health Plan is easy. Complete this enrollment form and return it to **PrimeTime Health Plan**. Mail **ALL** copies of this enrollment form, a copy of your Medicare card *(if available)*, the Electronic Funds Transfer *(EFT)* Form *(if applicable)* and the Attestation of Eligibility for an Enrollment Period to:

PrimeTime Health Plan
214 Dartmouth Ave SW, Suite 104
Canton, Ohio 44710-6119

We will mail you a copy of your enrollment form, your Evidence of Coverage, and a letter acknowledging your pending enrollment. This letter is proof of insurance that will allow you to access services until you receive your member identification card. Once Medicare confirms your enrollment, we will mail you a New Member Information Packet, including a confirmation letter with your actual effective date of coverage.

If, at any time, you need help with this enrollment form, please call the PrimeTime Health Plan Member Services Department at 330-363-7407 or 1-800-577-5084. TTY users should call 330-363-7460 or 1-800-617-7446. Our Lobby is open Monday through Friday from 8:00 a.m. to 4:30 p.m., E.S.T. Our Call Center is open Monday through Friday from 8:00 a.m. to 8:00 p.m., E.S.T.

TO ENROLL IN PRIMETIME HEALTH PLAN, PLEASE PROVIDE THE FOLLOWING INFORMATION:

MA-PD PPO Plan (H3620)

Your premium includes prescription drug coverage.

____ Prime PPO Plan (001): \$140

YOUR PERSONAL INFORMATION *(Please print in ink)*

Last Name: _____ First Name: _____ MI: _____

Permanent Residence Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Birth Date: _____
M M / DD / YYYY

County: _____ Sex: M ____ F ____

MAILING ADDRESS *(Only if different from your permanent address)*

Street Address: _____

City: _____ State: _____ Zip Code: _____

EMERGENCY CONTACT INFORMATION *(Optional)*

Name: _____ Phone: _____ Relationship To You: _____

YOUR PRIMARY CARE PHYSICIAN *(PrimeTime Health Plan network physician only)*


Name of Primary Care Physician: _____

MEDICARE 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	
SOCIAL SECURITY ACT	
Name of Beneficiary _____	
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 by 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% of 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.

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.

Please select ONE premium payment option: *(If you don't select a payment option, you will get a bill each month.)*

1. **Get a bill.**
2. **Electronic Funds Transfer (EFT)** from your bank account each month.
(If you choose this option, please complete the Electronic Funds Transfer Form enclosed and include a voided or cancelled check.)
3. **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 you have had a successful kidney transplant.
2. 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: _____ Phone Number of Institution: _____
Address of Institution (Number & Street): _____
3. Have you moved into this plan's service area within the last 90 days? Yes No
If "**yes**", what was the date of your move into our service area? _____
4. Are you enrolled in your State Medicaid program? Yes No
If "**yes**" please provide your Medicaid number: _____
5. Will you have other **prescription** drug coverage in addition to PrimeTime Health Plan?
(For example, other private insurance, TRICARE, Federal Employee Health Benefits coverage, VA benefits, or State Pharmaceutical Assistance Programs) 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: _____
6. Do you or your spouse work? Yes No
If "**yes**", is health care coverage provided for you? Yes No
If "**yes**", will you continue to carry this coverage while on PrimeTime Health Plan? Yes No
If "**yes**", does the employer have 20 or more employees? Yes No

Please contact PrimeTime Health Plan at 330-363-7407 or 1-800-577-5084 (TTY users should call 330-363-7460 or 1-800-617-7446) if you need information in another format or language. Our Lobby is open Monday through Friday from 8:00a.m. to 4:30p.m., E.S.T. Our Call Center is open Monday through Friday from 8:00a.m. to 8:00p.m., E.S.T.

PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining PrimeTime Health Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join PrimeTime Health 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 form, I agree to the following:

PrimeTime Health Plan 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. 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: Annual Enrollment Period from November 15 – December 31 of every year), or under certain special circumstances.

PrimeTime Health Plan serves a specific service area. If I move out of the area that PrimeTime Health Plan 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 PrimeTime Health 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 PrimeTime 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 PrimeTime Health Plan coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, PrimeTime Health Plan provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by PrimeTime Health Plan and other services contained in my PrimeTime Health Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR PRIMETIME 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 PrimeTime Health Plan, he/she may be paid based on my enrollment in PrimeTime Health Plan.

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 PrimeTime 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 PrimeTime 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 enrollment form means that I have read and understand the contents of this enrollment form. 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 PrimeTime Health Plan or by 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: _____

Please include a copy of the General Power of Attorney.

PrimeTime Health Plan Office Use Only:

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

Plan ID #: _____ Effective Date of Coverage: _____

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