

Today's Health® HMO

Medicare Advantage Health Plans

2010 Change Notice Form

Current Today's Health HMO members can use this change form to change their enrollment election to a different Today's Health HMO plan, change their premium payment option or to update contact information.

Section 1: Plan and Premium Payment Options

I am currently a member of the _____ plan in Abri Health Plan with a monthly premium of \$ _____.

Please check which plan you would like to change to:

- Classic powered by CCRx (HMO) \$ _____ per month
- Premier powered by CCRx (HMO) \$ _____ per month
- Value (HMO) \$ _____ per month

Section 2: Personal Information

MEDICARE HEALTH INSURANCE SAMPLE ONLY	
Last Name	Suffix
First Name	MI
Medicare Claim Number	
Is Entitled to Hospital Insurance (Part A)	Effective Date
Medical Insurance (Part B)	

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.
- Remember you must have Medicare Part A and Part B to join a Medicare Advantage plan, such as Today's Health HMO.

An incorrect or incomplete Medicare claim number may cause a delay or denial of coverage.

Member ID:

Primary Phone Number:

(____) _____ - _____

Permanent Residence Street Address Line 1: (May not be a P.O. Box)

Street Number Street Name

Permanent Residence Street Address Line 2: (Apt/Suite/Unit)

County:

City:

State:

ZIP Code:

Mailing Address: Same as permanent address

Mailing Street Address Line 1:

Street Number Street Name or P.O. Box Number

Mailing Street Address Line 2: (Apt/Suite/Unit)

County:

City:

State:

ZIP Code:

Section 4: Acknowledgement of Enrollment – Read and Sign Below

Today's Health HMO is a Medicare Advantage Private Fee-for-Service plan and has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Today's Health HMO, he/she may be paid based on my enrollment in Today's Health HMO.

Release of Information: By joining this Medicare health plan, I acknowledge that Today's Health HMO will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that Today's Health HMO 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 people with Medicare are not 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 Today's Health HMO coverage begins, I must get all of my healthcare from Today's Health HMO, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Today's Health HMO and other services contained in my Today's Health HMO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR TODAY'S HEALTH HMO WILL PAY FOR THE SERVICES.

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 Today's Health HMO or by Medicare.

Please indicate your enrollment period: AEP (11/15/2009 – 12/31/2009)
 OEP (1/1/2010 – 3/31/2010)

If SEP, please choose one of the reasons below:

- I am new to Medicare, but not 65.
- I am turning 65, but am not new to Medicare.
- I recently moved outside of the service area for my current plan. I moved on []/[]/[] .
- I recently moved and this plan is a new option for me. I moved on []/[]/[] .
- I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums.
- I get Extra Help paying form Medicare prescription drug coverage.
- I no longer qualify for Extra Help paying for my Medicare prescription drugs. I stopped receiving Extra Help on []/[]/[] .
- I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home, a Special Needs Care facility or other institution). I moved/will move into/out of the facility on []/[]/[] .

Section 4: Acknowledgement of Enrollment - Read and Sign Below *(continued)*

- I recently left a PACE program on ____/____/____.
- I no longer qualify for Special Needs assistance.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on ____/____/____.
- I am leaving employer or union coverage on ____/____/____.
- I belong to a pharmacy assistance program provided by my state.
- My current plan is ending its Medicare contract.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ____/____/____.
- I am eligible for coverage through the Department of Veteran Affairs.
- Other _____.

If your enrollment period is not listed or you have questions regarding your enrollment eligibility, please contact Today's Health HMO at 1-800-958-2704, 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 1-800-777-9083) everyday.

Your Signature:

Your Name: (please print)

Today's Date:

If you are legally authorized to represent the enrollee, you must provide the following information (not for agent use): (Power of Attorney (POA) documentation needs to be submitted with the application)

Name: _____

Address: _____

Phone Number: _____ Cell Phone Number: _____

Relationship to Enrollee: Child Friend Spouse Other__

Section 5: Agent and Today's Health HMO Use Only

Agent Name (please print): _____

Today's Date: ____/____/____

Agent ID #: _____

Agent Signature:

Plan Name: _____

Effective Date of Coverage: ____/____/____

Today's Health® HMO is a Medicare Advantage plan offered through the following organization that contract with the Federal government: Abri Health Plan, Inc. Today's Health is administered by Heritage Health System, Inc., a member of the Universal American family of companies.