Today's Health® HMO

Medicare Advantage Health Plans

2010 Enrollment Form

Follow these easy steps to enroll in a Today's Health Health Maintenance Organization.

Note: *Each applicant should fill out a separate enrollment form.*

1. Have your Medicare card ready. You will need to fill in the requested information EXACTLY as it appears on your Medicare card to avoid delays with your enrollment.
2. Read each section carefully to be sure that you understand the information. Print legibly and fill in each section completely.
3. Sign and date the enrollment form. (Your enrollment form is not complete until you sign and date it.)
4. If mailing in your application, use the enclosed envelope to send back the following:
    - Enrollment Application
    - Member Acknowledgement Form
    - Scope of Appointment
    - Power of Attorney documentation (if applicable)
    - Voided check (if applicable)
    - End Stage Renal disease documentation (if applicable)

Note: *If you have enrolled with us before, you may not need to fill out this enrollment form. Call us at 1-800-958-2710 (TTY users call 1-800-958-2692) to find out how you should enroll*

How to Submit your Enrollment:

Please fax your completed enrollment form to: 1-866-430-7452.
Or mail the form in the enclosed envelope to:

Regular Mail:	Overnight (For Agent Use Only):
Today's Health HMO P.O. Box 27772 Houston, TX 77227-9933	Today's Health HMO 4888 Loop Central Drive, Suite 700 Houston, TX 77081

You also have the option to enroll online instead at our Web site: www.todayshealthwi.com.

Have any questions? Call us 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) every day. We'll be glad to help.

Please do not submit the same application or apply to the same plan more than once to avoid delays with your enrollment.

Universal American

A Healthy Collaboration℠

2010 Today's Health HMO

Individual Enrollment Request Form *(For New Members Only)*

Section 1: To Enroll in Today's Health HMO Please Provide the Following Information
(You can find your plan premium in the enclosed Summary of Benefits)

Please check which plan you want to enroll in:

❏ Classic powered by CCRx $ ___ . __ per month ❏ Value $ ___ . __ per month

❏ Premier powered by CCRx $ ___ . __ per month

Section 2: Please Complete The Information Below Exactly As It Appears On Your Medicare Card.

Last Name ______ Suffix ___

First Name ______ MI ___

Medicare Claim Number ______

Is Entitled to — Effective Date

Hospital Insurance (Part A) __ / __ / ____

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.

-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, such as Today's Health HMO.

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

Birth Date: __ __ / __ __ / __ __ __ __ (M M / D D / Y Y Y Y)

Sex: ❏ M ❏ F

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:**

E-mail Address:

Section 3: Paying Your Plan Premium

You can pay your Medicare Advantage plan monthly premium, or any determination of a late enrollment penalty, by mail, by Automatic Bank Draft Withdrawal, or by automatic deduction from your monthly Social Security benefit check. ***If you have selected a $0 premium plan without prescription drug coverage, you do not need to fill out this section.***

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a 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 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 does not cover.

How would you like to pay your monthly Medicare Advantage plan premium? If you don't select a payment option, you will get a bill each month. Please check the appropriate box:

❑ Automatic Bank Draft Withdrawal. Please send us a VOIDED check and fill in the requested information, which allows us to deduct your monthly payment from your bank account.

By selecting Automatic Bank Withdrawal, I authorize the bank or financial organization named below to pay my premium through electronic bank withdrawal payable to Today's Health HMO. The bank or other financial organization will be fully protected in honoring these payments until written notice from me canceling this request is received.

Please choose one of the following: ❑ Checking ❑ Savings

Name on Account: ______________________

Financial Institution: ______________________

Routing Number: ______________________

Account Number: ______________________

Name
Address
City, State Zip
2008
Date
Pay to the order of
$
Dollars
VOID
Memo
⑆123456789⑆ ⑈12 3456789⑈ 2008

Routing Number Account Number

Account Holder Signature ______________________

❑ Monthly payments by personal check. You will be mailed a premium statement each month. ***Do not send payment with this enrollment form***.

❑ Social Security benefit check deduction. Please note: Social Security Administration (SSA) deduction is completed through the SSA and may take three or more months to process. (The SSA deduction may take three or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Section 4: 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 do not 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 do not need dialysis or 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:

Address of Institution (number and street):

City: **State:** **Zip Code:**

Phone Number: — —

3. Are you enrolled in your state Medicaid program? ❑ Yes ❑ No
If "yes," please provide your Medicaid number:

4. Are you or your spouse employed? ❑ Yes ❑ No

Complete if MA-PD plan is selected

5. 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 a Today's Health HMO plan? ❑ Yes ❑ No

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

Name of Coverage:
ID# for This Coverage:
Group# for This Coverage:

6. ❑ Please check this box if you would prefer information in Spanish.
Please contact Today's Health HMO at 1-800-958-2710, 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call TTY 1-800-958-2692) every day, if you need information in another format or language.

Section 5: Primary Care Selection

As a Today's Health HMO member, you will have a primary care physician (PCP) who will be coordinating your healthcare. Please choose the name of a primary care physician from our list of network physicians, which can be obtained from your agent, on our website at **www.todayshealthwi.com**, or by calling Customer Service at 1-800-958-2710, 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 1-800-958-2692) every day. If you do not select one of the primary care physicians from our list, the plan will automatically choose one for you.

Physician Name:
Address:

City: **State:** **Zip Code:**

Are you currently a patient of the physician: ❑ Yes ❑ No

Section 6: Please Read This Important Information

If you currently have health coverage from an employer or union, joining Today's Health HMO could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Today's Health 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 is not any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Section 7: Please Read and Sign on Page 6

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

Today's Health 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 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 do not 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.

Today's Health HMO serves a specific service area. If I move out of the area that Today's Health 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 Today's Health HMO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Today's Health HMO 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 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 health care 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 if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Today's Health HMO, he or she may be paid based on my enrollment in Today's Health HMO.

Authorization to release 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 health care 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 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.

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. ***(for example, if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage; if you do not 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.

Please indicate your enrollment period:

- ❑ AEP (If today's date is between 11/15/09 – 12/31/09)
- ❑ OEP (If today's date is between 1/1/10 – 3/31/10)
- ❑ ICEP - I am new to Medicare
- ❑ IEP - I had Medicare due to disability, and am now turning 65

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 for 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 __/__/____.
- ❑ 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 ____________________.*

*To see if you are eligible to enroll, 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:	**Today's Date:** __/__/____

Print Name: ***(please print)***

Section 8: Power of Attorney/Authorized Representative

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

Name:

Address:

City: **State:** **Zip Code:**

Phone Number: — —

Relationship to Enrollee: ❑ Child ❑ Friend ❑ Spouse ❑ Other

Signature: ____ **Today's Date:** / /

Agent Use Only

Agent Name: ***(please print)***

Today's Date: / / **Proposed Effective Date:** / /

Agent ID Number: **Agent Signature:** ________________________

POS: ❑ In-store pharmacy ❑ In-office at physician practice ❑ Pharmacy material lead
❑ Physician material lead ❑ Seminar ❑ Other ________________________________

If you are submitting this application through the AgentLink process, remember to print and complete the cover sheet, indicating the subscriber ID. Fax or mail in the cover sheet along with a copy of this application **within 24 hours of receipt of AgentLink confirmation**.

Internal Use Only

APPLICATION RECEIPT TRACKING

Initial Receipt Date at Field Office:	Medicare Services Inventory Control Receipt:	Medicare Services Deemed Complete:
/ /	/ /	/ /

Group Code:

Provider #: **Cycle #** **PBP #**

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