Generations Healthcare HMO

Medicare Advantage Health Plans

2012 Enrollment Form

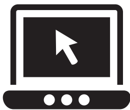
Follow these easy steps to enroll in a Generations Healthcare Health Maintenance Organization.

1. Each applicant must fill out a separate enrollment form.
2. 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.
3. Sign and date the enrollment form. Your enrollment form is not complete without a signature.

There are three easy ways to submit your enrollment:

Local sales agent:

Contact your local sales agent to help you choose the right plan for you and to complete your enrollment.



Enroll online:

You have the option to enroll online at our website:

www.Universal-American-Medicare.com

or Mail:

Fill out this paper enrollment form and mail it, along with any other required documentation, to us in the enclosed envelope to:

Generations Healthcare HMO
P.O. Box 740445
Houston, TX 77274

Call us:

If you have any questions, call us at 1-866-618-4074, 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 1-800-975-8089) 7 days a week. We'll be glad to help.

Your agent may fax your completed enrollment form to **1-866-903-8235**.

Please do not submit your enrollment information more than once to avoid delays with your enrollment.

UNIVERSAL AMERICAN

A Healthy Collaboration®

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2012 Generations Healthcare HMO

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

Where did you get this form? ❑ Online ❑ Event ❑ Agent ❑ Retail Pharmacy ❑ Requested by phone

Section 1: To Enroll in Generations Healthcare 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:

- ❑ Generations Healthcare Value (HMO) (MA-Only) $ ____ . __ per month
- ❑ Generations Healthcare Classic (HMO) (MA-PD) $ ____ . __ per month
- ❑ Generations Healthcare Premier (HMO) (MA-PD) $ ____ . __ per month

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

MEDICARE SAMPLE ONLY HEALTH INSURANCE

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 Generations Healthcare.

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

To Enroll in Generations Healthcare, Please Provide the Following Information

Birth Date: M M / D D / Y Y Y Y

Sex: ❑ M ❑ F

Primary Phone Number: ( ) —

Cell 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:

By providing your e-mail address, you agree to receive electronic correspondence from the plan.

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Section 3: Paying Your Plan Premium

You can pay your Medicare Advantage plan monthly premium, including any late enrollment penalty you currently have or may owe, by mail, by Automatic Bank Draft Withdrawal, or by automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. 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 from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Generations Healthcare the Part D-IRMAA. ***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 Generations Healthcare. 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
Memo
VOID
⑆123456789⑆ ⑈12 3456789⑈ 2008
Routing Number Account Number

Account Holder Signature ______________________

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

❑ Social Security benefit check deduction.

❑ Railroad Retirement Board (RRB) benefit check deduction.

Please note: 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.

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Section 4: 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 do not need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you do not need dialysis, otherwise we may need to contact you to obtain additional information.

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

Please complete this section if you have selected a MA-PD plan.

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 Generations Healthcare 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.

   If you need information in another format or language, please contact Generations Healthcare at 1-866-547-3060, 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 1-800-958-2692) 7 days a week.

Section 5: Primary Care Selection

As a Generations Healthcare member, you will have a Primary Care Physician (PCP) who will be coordinating your healthcare. Please choose the name of a PCP from our list of network physicians, which can be obtained from your agent, on our website at **www.GenerationsHealthcare.cc**, or by calling Customer Service at 1-866-547-3060, 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 1-800-958-2692) 7 days a week. If you do not select one of the PCPs from our list, the plan may automatically choose one for you.

Physician First Name:

Physician Last Name:

Address:

City: **State:** **ZIP Code:**

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

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Section 6: Please Read This Important Information

If you currently have health coverage from an employer or union, joining Generations Healthcare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Generations Healthcare. 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:

Generations Healthcare 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 have not selected a plan that includes prescription drug coverage, and if I do not have Medicare prescription drug coverage, or creditable drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in a 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.

Generations Healthcare serves a specific service area. If I move out of the area that Generations Healthcare 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 Generations Healthcare, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Generations Healthcare 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 Generations Healthcare coverage begins, I must get all of my healthcare from Generations Healthcare, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Generations Healthcare and other services contained in my Generations Healthcare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR Generations Healthcare 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 Generations Healthcare, he or she may be paid based on my enrollment in Generations Healthcare.

Authorization to release information:

By joining this Medicare health plan, I acknowledge that Generations Healthcare will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that Generations Healthcare will release my information, including my prescription drug event data if applicable, 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.

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Section 7 (continued): Please Read and Sign Below

Typically, you may enroll in a Medicare Advantage plan only during the Annual Election Period from October 15 through December 7 of each year.

There are exceptions, called Special Election Periods, that may allow you to enroll in a Medicare Advantage plan outside of this period. 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:

- ❑ Annual Election Period (AEP)
- ❑ Initial Coverage Election Period (ICEP) - I am new to Medicare
- ❑ Initial Election Period (IEP) - I had Medicare due to disability, and am now turning 65

If Special Election Period (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, or Medicare is ending its contract with my plan on ___/___/_____.
- ❑ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on ___/___/_____.
- ❑ 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 none of these statements applies to you or you are not sure if you are eligible to enroll, please contact Generations Healthcare at 1-866-618-4074, 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 1-800-975-8089) 7 days a week.

Applicant's Signature

Your Signature:	**Today's Date:** ___/___/_____

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

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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):

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)***

Proposed Effective Date: / / **Agent ID Number:**

Agent Signature: ______________________

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 and your scope of appointment confirmation or paper scope of appointment form **within 24 hours of receipt of AgentLink confirmation**. Fax number and mail address can be found on the front cover of this form.

Scope of Appointment information:

❑ Phone Confirmation # ______________________ ❑ Paper (Please fax along with application)

Agent Use Only — Please Complete

How did you meet this applicant?

❑ Approved lead card ❑ In pharmacy ❑ DRTV
❑ Personal marketing appointment ❑ Pharmacy marketing material ❑ Physician marketing
❑ Sales event/Seminar ❑ Web lead ❑ Other ______________

Lead number: ❑ Primary ❑ Spouse

Internal Office Use Only

Initial Receipt Date: / / **PBP #:**

A health plan with a Medicare contract.

Generations Healthcare HMO is offered by the following organization that contracts with the Federal government: Today's Options of Oklahoma, Inc., a member of the Universal American family of companies.