Follow these easy steps to enroll in a TexanPlus® 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.

**How to Submit your Enrollment:**

Please fax your completed enrollment form to **1-866-903-8235**

Or mail the form in the enclosed envelope to:

TexanPlus HMO
P.O. Box 18400
Austin, TX 78760-8400

Have any questions?:

Call us at 1-866-556-4607, 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 711) every day. We’ll be glad to help.

Please do not submit your enrollment information more than once to avoid delays with your enrollment.
**Employer Group Enrollment Request Form (For New Members Only)**

**Section 1**
To Enroll in TexanPlus HMO Plan Please Provide the Following Information (You can find your plan premium in the enclosed Summary of Benefits)

<table>
<thead>
<tr>
<th>Employer Name: City of Houston</th>
<th>Group #: E0000005</th>
</tr>
</thead>
</table>

To enroll, please check the plan below:

- TexanPlus – City of Houston Group Retirees (HMO) (MA-PD) $ per month

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

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.

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

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>Suffix:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First Name:</th>
<th>MI:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medicare Claim Number:

Is Entitled to Effective Date:

Hospital Insurance (Part A)

Medical Insurance (Part B)

**To Enroll in TexanPlus HMO, Please Provide the Following Information**

<table>
<thead>
<tr>
<th>Birth Date: M M D D Y Y Y Y</th>
<th>Sex: ❏ M ❏ F</th>
<th>Primary Phone Number: — —</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Cell Phone Number: — —</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Street Number</th>
<th>Street Name</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>County:</th>
</tr>
</thead>
</table>

City:  

<table>
<thead>
<tr>
<th>State:</th>
<th>ZIP Code:</th>
</tr>
</thead>
</table>

Mailing Address: ❏ Same as permanent address
**Section 2 (Cont.)**

To Enroll in TexanPlus HMO, Please Provide the Following Information

<table>
<thead>
<tr>
<th>Mailing Street Address Line 1:</th>
<th>Street Number</th>
<th>Street Name or P.O. Box Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing Street Address Line 2: (Apt/Suite/Unit)</td>
<td>County:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
<td>ZIP Code:</td>
</tr>
<tr>
<td>E-mail Address:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**Section 3**

Please Read and Answer These Important Questions

1. Are you the retiree?  □ Yes □ No
   - If yes, retirement date (month/date/year): __/__/____
   - If no, name of retiree: ____________________________

2. Are you covering a spouse or dependents under this employer or union plan?  □ Yes □ No
   - If yes, name of spouse: ____________________________
   - Name of dependents: ______________________________

3. Do you or your spouse work?  □ Yes □ No

4. 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.

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 TexanPlus 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: _____________________
### Section 3 (Cont.)

**Please Read and Answer These Important Questions**

6. 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:** [ ]  

7. [ ] Please check this box if you would prefer information in Spanish.

   If you need information in another format or language, please contact TexanPlus HMO at 1-866-230-2513, 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 711) 7 days a week.

### Section 4

**Primary Care Selection**

As a TexanPlus HMO 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.TexanPlus.com](http://www.TexanPlus.com), or by calling Member Services at 1-866-230-2513, 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 711) 7 days a week. If you do not select one of the primary care physicians 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
Section 5  Please Read and Sign Below

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

TexanPlus 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. 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 October 15 – December 7), or under certain special circumstances.

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

Authorization to release information:

By joining this Medicare health plan, I acknowledge that TexanPlus HMO will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that TexanPlus HMO 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.

<table>
<thead>
<tr>
<th>Applicant’s Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature: [Signature]</td>
</tr>
</tbody>
</table>

Print Name: (please print) [Print Name]
Section 6  Power of Attorney/Authorized Representative

If you are legally authorized to represent the enrollee, you must provide the following information (not for agent use):

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>City:</td>
<td>State: ZIP Code:</td>
</tr>
<tr>
<td>Phone Number:</td>
<td></td>
</tr>
</tbody>
</table>

**Relationship to Enrollee:**
- ❏ Child
- ❏ Friend
- ❏ Spouse
- ❏ Other

**Signature:**

**Today’s Date:**

**Agent Use Only**

**Agent Name (please print):**

**Proposed Effective Date:**

**Agent 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)

**Internal Office Use Only**

**Initial Receipt Date:**

**PBP #:**

TexanPlus® HMO is a Medicare Advantage plan with a Medicare contract. Enrollment in TexanPlus® HMO depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/co-insurance may change on January 1 of each year. ATTENTION: If you speak other languages, language assistance services, free of charge, are available to you. Call 1-888-736-7442 (TTY: 711). ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-736-7442 (TTY: 711).
Discrimination is Against the Law

TexanPlus® HMO, TexanPlus® HMO-POS, TexanPlus® HMO-SNP, Today’s Options® PFFS, and Today’s Options® PPO (hereinafter, the Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  – Qualified sign language interpreters
  – Written information in other formats (large print, audio, accessible electronic formats, other formats)
• Provides free language services to people whose primary language is not English, such as:
  – Qualified interpreters
  – Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Your Plan Name, P.O. Box 18200, Austin, TX 78760-8200, c/o Appeals and Grievances, 1-866-422-1690 (TTY users call 711), Fax: 1-800-817-3516, Email: AGMailbox@UniversalAmerican.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Spanish:

Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-736-7442 (TTY: 711)。

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-736-7442 (телетайп: 711).

French:

Vietnamese: