# flexcare MAPD plan 6

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|---|---|
| **A99524730637906M** | A99524730637906M |
| Selected Plan | flexcare MAPD plan 6 |
| Monthly Premium | $0.00 |
| Application Date | 09/12/2017 |
| Contact Information | flexcare<br>123 Any Street<br>Los Angeles, CA 90010<br>www.drx.com |
| Business Phone | 1-800-379-9060 |
| Member Name | drxtest drxtest |
| Member Address | 555 drxtest<br>drxtest, CA 90014 |
| Contract/Plan/Segment ID | H9999_025_000 |

CONTACT INFO | BENEFIT INFO | OTHER INFO | REVIEW | AGENT INFO | SUBMIT

## CONTACT INFORMATION

Use the form below to apply to the plan. You'll be able to review your information and make changes before you submit your completed form.

Please contact the plan directly if you need information in another language or format (Braille).

Fields marked with an asterisk (*) are required

## PERSONAL INFORMATION

Please enter your personal information in the spaces provided.

| | |
|---|---|
| Title | ○ Mr. ○ Mrs. ○ Ms. |
| First Name * | drxtest |
| Middle Initial | |
| Last Name * | drxtest |
| Date of Birth * | 01/01/1952 |
| Gender * | ○ Male ◉ Female |
| Home Phone Number * | 5555555555 |

*Please enter your 10 digit phone number with no hyphen or spaces (e.g., 2125551212).*

| | |
|---|---|
| Email Address | lpena@connecture.com |

Providing an email address authorizes us to contact you via email. Your email address will be handled consistent with our Privacy Policy.

## PERMANENT RESIDENCE

Please enter your permanent residence address below. (P.O. Box is not allowed.)

| | |
|---|---|
| Address (Line 1) * | 555 drxtest |
| Address (Line 2) | |
| City * | drxtest |
| State * | CA |
| ZIP Code * | 90014 |

## MAILING ADDRESS

Do you have a separate mailing address where you like to receive correspondence?

○ Yes ◉ No

## EMERGENCY CONTACT

Would you like to provide an emergency contact?

○ Yes ◉ No

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## BENEFITS INFORMATION

Please tell us about your current Medicare coverage and related benefits information.

You can save your progress on this enrollment application if you want to come back and finish it later by using the *Save and Exit* option at the bottom of this page.

Fields marked with an asterisk (*) are required

## MEDICARE INFORMATION

Please take our your red, white and blue Medicare card to complete this section. In the spaces provided, enter your Medicare Number and the Effective Dates for your Part A and Part B coverage.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

| | |
|---|---|
| Medicare Number * | 123456789A |
| Hospital (Part A) Effective Date *(MM/DD/YYYY)* | 09/01/2017 |
| Medical (Part B) Effective Date *(MM/DD/YYYY)* | 09/04/2017 |

## END STAGE RENAL DISEASE

Do you have End Stage Renal Disease, or ESRD? *

○ Yes ◉ No

## PRESCRIPTION DRUG COVERAGE

Some individuals may have additional prescription drug coverage, including other private

insurance, TRICARE, federal employee health benefits, VA benefits, or state pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to this plan? *
○ Yes ◉ No

## LONG TERM CARE

Are you a resident in a long-term care facility, such as a nursing home? *
○ Yes ◉ No

## MEDICAID ENROLLMENT

Are you enrolled in your state Medicaid program? *
○ Yes ◉ No

## EMPLOYMENT INFORMATION

Do you or your spouse work? *
○ Yes ◉ No



## OTHER INFORMATION

## PHYSICIAN SELECTION (OPTIONAL)

Please provide the name of a Primary Care Physician (PCP), clinic, or health center: Dr. Thomas

## PAYING YOUR PLAN PREMIUM

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail, Electronic Funds Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), 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 Railroad Retirement Board . DO NOT pay [Your Client Name] the Part D-IRMAA.

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail, Electronic Funds Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad

Retirement Board benefit check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more 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 qualify 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 http://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.

If you don't select a payment option, you will get a bill each month.

**Please select a premium payment option:** *

- (•) Get a Bill
- ( ) Electronic funds transfer (EFT) from your bank account each month
- ( ) Credit Card
- ( ) Automatic deduction from your monthly Social Security/Railroad Retirement Board (RRB) benefit check.

(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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## REVIEW

Please review the information that you have entered. Click *Continue* to review the next page in the form. If you need to make a change, choose *Edit* at the bottom of the Review section.

Once you have verified that your information is correct, identify the person filling out this form, then select *Complete Review.*

You can save your progress on this enrollment application if you would like to come back and finish it later by using the *Save and Exit* option at the bottom of the page.

CONTACT INFO | BENEFIT INFO | OTHER INFO | REVIEW | AGENT INFO | SUBMIT

## AGENT INFORMATION

Review the Agent information below and signify your acceptance of this attestation to continue.

Agent Name: PEOTest1234 PEOTest1234
Agent ID/NPN: PEOTest1234

**AS THE WRITING AGENT, I HEREBY ATTEST THAT:**

1. I am appropriately licensed to sell this product and appointed by the carrier to do so.
2. I have provided the applicant with the information necessary to make a sound, informed voluntary decision to enroll in this plan, understanding the implications of enrollment in areas including but not limited to benefit coverage, potential out-of-pocket costs, availability of specific medications on formulary, and network pharmacies.
3. The applicant has read this statement in person or I have read the statement aloud to the applicant and the applicant grants me permission to submit the application on his/her behalf.

* ☑ I agree with the above statements.

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## SUBMIT

## READ THIS IMPORTANT INFORMATION

Please read the legal information. After you complete your review, check the acknowledgment that you read the disclosures. Click *Submit Enrollment* to send us your enrollment form.

You can save your progress on this enrollment application if you want to come back and finish it later by using the *Save and Exit* option at the bottom of this page.

**If you currently have health coverage from an employer or union, joining flexcare MAPD plan 6 could affect your employer or union health benefits. You could lose your employer or union health coverage if you join flexcare MAPD plan 6.** 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.

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

flexcare MAPD plan 6 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

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: October 15 – December 7 of every year), or under certain special circumstances.

flexcare MAPD plan 6 serves a specific service area. If I move out of the area that flexcare MAPD plan 6 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 flexcare MAPD plan 6, I have the right to appeal plan decisions about payment or services if I disagree. I will read either the Member Handbook or Evidence of Coverage document from flexcare MAPD plan 6 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 flexcare MAPD plan 6 coverage begins, I must get all of my health care from flexcare MAPD plan 6, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by flexcare MAPD plan 6 and other services contained in my flexcare MAPD plan 6 Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR flexcare MAPD plan 6 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 flexcare MAPD plan 6, he/she may be paid based on my enrollment in flexcare MAPD plan 6.

**Release of Information:**

By joining this Medicare health plan, I acknowledge that flexcare MAPD plan 6 will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that flexcare MAPD plan 6 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 from Medicare.

**Please select the statement below that best describes your relationship to the person with Medicare listed on this enrollment form:** *

◉ I am the person listed on this enrollment form or I am simply helping to complete this enrollment form.

○ I am the person authorized to act on behalf of the individual listed on this enrollment form under the laws of the State where the individual resides.

*

☑ I understand that my submission (or submission of the person authorized to act on my behalf under the laws of the State where I live) of this application means that I have read and understand the contents of this application, and that I confirm that the information I have provided is accurate. If submitted by an authorized individual (as described above), this submission 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 Medicare.