

FamilyCare Health Plans, Inc.  
 825 NE Multnomah, Suite 300  
 Portland, OR 97232  
 www.familycareinc.org

1-866-225-CARE (2273)  
 Fax: 503-345-5751  
 (TTY 1-800-735-2900)  
 Monday - Friday 8 am to 8 pm



Please contact FamilyCare Health Plans if you need information in another language or format (Braille).

**To Enroll in FamilyCare Health Plans, Please Provide the Following Information:**

Please check which plan you want to enroll in: \_\_\_\_\_ PremierCare Choice (HMO); \$0.00 per month  
 \_\_\_\_\_ PremierCare Advantage Rx (HMO); \$99.00 per month \_\_\_\_\_ PremierCare Plus (HMO); \$0.00 per month (with LIS)  
 \_\_\_\_\_ PremierCare Value (HMO); \$50.00 per month \_\_\_\_\_ PremierCare Select Rx (HMO); \$129.60 per month  
 \_\_\_\_\_ PremierCare Choice Rx (HMO); \$35.60 per month (Diabetic C-SNP)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  Mr.  Mrs.  Ms.

Birth Date: (MM/DD/YYYY) \_\_\_\_\_ Sex:  M  F Home Phone Number: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Permanent Residence Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Mailing Address (only if different from your Permanent Residence Address):  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Relationship: \_\_\_\_\_

**Please Provide Your Medicare Insurance Information**

Please take our 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 the Social Security Administration or the Railroad Retirement Board.

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



Name: \_\_\_\_\_ Sex:  M  F

Medicare Claim Number: \_\_\_\_\_

Is Entitled To: \_\_\_\_\_ Effective Date (MM/DD/YYYY) \_\_\_\_\_

HOSPITAL (Part A) \_\_\_\_\_

MEDICAL (Part B) \_\_\_\_\_

**Paying Your Plan Premium**

You can pay your monthly premium by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, 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 will not be subject to the 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 should call 1-800-325-0778. You can also apply for extra help online at [www.socialsecurity.gov/prescriptionhelp](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. (A QuickPay form must be completed and submitted for this option)
- Automatic deduction from your monthly Social Security benefit check. (The SSA deduction may take two 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.)



**Please Read and Answer These Important Questions**

1. Do you have End-Stage Renal Disease (ESRD)?  YES  NO  Agent  
*If you answered "YES", to this question and you don't need regular dialysis any more, or if you have had a successful kidney transplant, please attach a note or record from your doctor showing you don't need dialysis or have had a successful kidney transplant.*

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.  Agent  
 Will you have other prescription drug coverage in addition to FamilyCare Health Plans?  YES  NO  
*If "YES", please list your other coverage and your identification (ID) number for this coverage:*  
 Name of other coverage: \_\_\_\_\_ ID # for this coverage: \_\_\_\_\_ Group # for this coverage: \_\_\_\_\_

3. Are you a resident of a long-term care facility, such as a nursing home?  YES  NO  Agent  
*If "YES", please provide the following information:*  
 Name of Institution: \_\_\_\_\_  
 Address of institution (number and street): \_\_\_\_\_  
 Phone Number of institution: \_\_\_\_\_

4. Are you enrolled in your State Medicaid program?  YES  NO Agent   
 If "YES", please provide your Medicaid number: \_\_\_\_\_

5. Do you or your spouse work?  YES  NO Agent

6. FOR PREMIERCARE SELECT Rx APPLICANTS ONLY - Do you have diabetes?  YES  NO Agent

7. Please choose the name of a Primary Care Provider (PCP), clinic or health center:  Agent For internal use only:  
PCP ID: \_\_\_\_\_

8. Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:  Agent  
 Spanish  Russian  Vietnamese  Braille  Audio tape  Large print  
 Please contact FamilyCare Health Plans Customer Service at 866-798-2273 if you need information in another format or language. Our office hours are Monday through Friday 8:00 am to 8:00 pm. TTY users should call 800-735-2900.

9. 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 each year, as long as you do not change your 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.  Agent

- |  |   |
|--|---|
| <input type="checkbox"/> I am new to Medicare .  | <input type="checkbox"/> I live in or recently moved out of a Long Term Care Facility (for example, a nursing home or long term care facility). |
| <input type="checkbox"/> I recently moved outside of the service area for my current plan.                 | <input type="checkbox"/> I recently left a PACE program.  |
| <input type="checkbox"/> I recently moved and this plan is a new option for me.                            | <input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).               |
| <input type="checkbox"/> I receive extra help paying for Medicare Prescription drug coverage.              | <input type="checkbox"/> I am leaving employer or union coverage.   |
| <input type="checkbox"/> I am no longer eligible for extra help paying for my Medicare prescription drugs. | <input type="checkbox"/> I belong to a pharmacy assistance program provided by my state.  |
|  | <input type="checkbox"/> I recently returned to the United States after living permanently outside of the US.                                   |

If none of these statements applies to you, please contact FamilyCare Health Plans at 866-798-2273, TTY users should call 800-735-2900, to see if you are eligible to enroll. We are open Monday through Friday 8:00 am to 5:00 pm.



**Please Read This Important Information**



**If you currently have health coverage from an employer or union, joining FamilyCare Health Plans could affect your employer or union health benefits.** You could lose your employer or union health coverage if you join FamilyCare Health Plans. 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.



Agent

**Please Read and Sign Below**

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



Agent

FamilyCare Health Plans 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 don't 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.

FamilyCare Health Plans serves a specific service area. If I move out of the area that FamilyCare Health Plans 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 FamilyCare Health Plans, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from FamilyCare Health Plans 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 US border.

I understand that beginning on the date FamilyCare Health Plans coverage begins, I must get all my health care from FamilyCare Health Plans, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by FamilyCare Health Plans and other services contained in my FamilyCare Health Plans Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR FAMILYCARE HEALTH PLANS WILL PAY FOR THESE SERVICES.

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

By joining this plan, I confirm that I am not getting any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) to buy medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage or Medicare Prescription Drug Plan.

**Release of Information**

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



Agent

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 Oregon Law to complete this enrollment and 2) documentation of this authority is available upon request by FamilyCare Health Plans or by Medicare.

Your Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

If you are the authorized representative, you must sign above and provide the following information:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship to Enrollee: \_\_\_\_\_

**Producing Agent - Please Read and Sign Below**

I, (Agent Name) \_\_\_\_\_ have explained the above provisions to the applicant. I have not made any statements about benefits, conditions, or limitations of the agreements except through written material furnished by FamilyCare Health Plans. The applicant has been informed that the effective date of coverage is assigned only by the Centers for Medicare and Medicaid Services (CMS).

I certify that the information supplied to me by the applicant has been truly and accurately recorded here.

Agent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agent Firm (if applicable): \_\_\_\_\_ Agent Number: \_\_\_\_\_

**Office Use Only:**

Name of staff member (if assisted in enrollment): \_\_\_\_\_ Plan ID#: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_ ICEP/IEP: \_\_\_\_\_ OEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP (type): \_\_\_\_\_ Not Eligible: \_\_\_\_\_

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