



## Plan to Plan Transfer Form

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

Please name the plan you want to enroll in: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Current Member ID: \_\_\_\_\_ Medicare Number: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

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

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

Mailing Address: (only if different from your Permanent Street Address):

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Please fill out the following:

I am currently a member of the \_\_\_\_\_ plan in FamilyCare Health Plans with a monthly plan premium of \$ \_\_\_\_\_.

I would like to change to the \_\_\_\_\_ plan in FamilyCare Health Plans. I understand that this plan has different health benefits and monthly premium of \$ \_\_\_\_\_.

Please check on of the boxes below if you would prefer us to send you information in a language other than English or in another format:

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.

### Paying Your Plan Premium

You can pay your monthly plan premium by mail or by Electronic Funds Transfer (ETF) each month. You can also choose to pay your premium by automatic deduction from your Social Security 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 [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 (ETF) from your bank account each month. (A Quickpay form must be completed and submitted to take advantage of this option.)
- Automatic deduction from your monthly Social Security check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up the point withholding begins.)

**Please Read and Sign Below:**

FamilyCare Health Plans is a plan that has a contract with the Federal government.

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.

**Release of Information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan 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. I understand that people with Medicare aren't covered under Medicare while out of the country, except for limited coverage near the U.S border.

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 plan or Medicare Drug 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 the application means that I have read and understand the content 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 FamilyCare Health Plans or by Medicare.

<b>Your Signature:</b>	<b>Today's Date:</b>
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If you are the authorized representative, you must provide the following information:

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Relationship to Enrollee:** \_\_\_\_\_

**Official Use Only:**  
Name of the staff member (if assisted in enrollment): \_\_\_\_\_  
Plan ID #: \_\_\_\_\_  
Effective Date of Coverage:  
ICEP/IEP:     OEP:     AEP:     SEP (type): \_\_\_\_\_    Not Eligible: \_\_\_\_\_