Enrollment Request Form Instructions 2019 Plan Year

Please read before completing your enrollment request form.

You are eligible to join HealthTeam Advantage Health Plan(s) PPO if:

- You are entitled to Medicare Part A and are enrolled in Part B;
- You do not have End Stage Renal Disease (ESRD);
- You live in Alamance County, Guilford County, Randolph County or Rockingham County;
- You are a United States Citizen or lawfully present in the United States.

Please make sure you complete all necessary information on the enrollment request form and send all of the information to HealthTeam Advantage.

1. Complete all sections of the enrollment request form in full, including the plan you want to enroll in and your premium payment option. Missing or incomplete information may cause delay in the effective date of your coverage.
2. If you are using a mailing address that is different from your permanent residential address, please provide the name of the person and his/her address to which mail should be sent.
3. When completing the Medicare insurance information, please print your name exactly as it appears on your Medicare card.
4. Provide the name of your Primary Care Physician (PCP).
5. If you would prefer to receive information in a language other than English or in another format, please check the box indicated.
6. Your enrollment request form must be signed, dated, and received by HealthTeam Advantage by the last calendar day of the month in order for your coverage to be effective the first day of the following month.
7. Mail completed enrollment request form to HealthTeam Advantage at:

HealthTeam Advantage
Attn: Enrollment Department
7800 McCloud Road, Suite 100
Greensboro, NC 27409

Other Important Information

- If you have questions about your enrollment request form, please call us at 1-877-905-9216 (TTY 711). A benefit consultant is available to help you seven days a week, 8 a.m. to 8 p.m. A benefit consultant will meet with you in-person to help you with your enrollment request form, if you prefer.
- HealthTeam Advantage determines when your enrollment request form is considered to be complete based on Medicare enrollment guidelines.
- Your enrollment with HealthTeam Advantage is subject to approval by the Centers for Medicare & Medicaid Services (CMS). If your enrollment is not accepted by CMS, we will notify you immediately.
- HealthTeam Advantage is not a Medicare Supplement. By enrolling in one of our plans, you will remain a part of the Medicare program. By selecting one of our plans, you will have Part C and Part D (MA-PD), which replaces Part A, Part B, and Part D (drug coverage).
- You may also enroll directly online or by phone. Go to www.healthteamadvantage.com, or call 1-877-905-9216, TTY users call 711.

HealthTeam Advantage, a product of Care N' Care Insurance Company of North Carolina, Inc., is a Medicare Advantage organization with a Medicare contract. Enrollment in HealthTeam Advantage depends on contract renewal. HealthTeam Advantage complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HealthTeam Advantage does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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Please contact HealthTeam Advantage if you need information in another acceptable language or format (Braille).

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

Please check which plan you want to enroll in:

MA-PD Plans:

- ☐ HealthTeam Advantage Plan I PPO $0 per month
- ☐ HealthTeam Advantage Plan II PPO $60 per month

Optional Supplemental Benefits Riders:

- ☐ HealthTeam Advantage Comprehensive Dental Rider $25 per month

LAST Name:	FIRST Name:	Middle Initial:	☐ Mr. ☐ Ms. ☐ Mrs.

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

Permanent Residence Street Address (P.O. Box is not allowed):

City:	County:	State:	ZIP Code:

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

City:	County:	State:	ZIP Code:

Emergency Contact:	Phone Number:	Relationship to You:

E-mail Address:

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled To: Effective Date:

HOSPITAL (Part A)

MEDICAL (Part B)

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

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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 or "Electronic Funds Transfer (EFT)" each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. 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 HealthTeam Advantage the Part D-IRMAA.

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or "Electronic Funds Transfer (EFT)" each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

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 RRB. DO NOT pay HealthTeam Advantage the Part D-IRMAA.

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.

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 Monthly
- ☐ Electronic funds transfer (EFT) from your bank account each month.
  Please enclose a VOIDED check or provide the following:

  Account Holder Name: _____

  Bank Routing Number: _____

  Bank Account Number: _____

  Account type: ☐ Checking ☐ Savings
- ☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.
  I get monthly benefits from: ☐ Social Security ☐ RRB

(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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Please read and answer these important questions:

1. Do you have End--Stage Renal Disease (ESRD)?
If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

☐ **Yes** ☐ **No**

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.

☐ **Yes** ☐ **No**

Will you have other prescription drug coverage in addition to HealthTeam Advantage Health Plan?
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage	ID # for this coverage	Group # for this coverage

3. Are you a resident in a long-term care facility, such as a nursing home?
If "yes," please provide the following information:

☐ **Yes** ☐ **No**

Name of Institution: _____
Address & Phone Number of Institution (number and street):
_____

4. Are you enrolled in your State Medicaid program?
If yes, please provide your Medicaid number: _____

☐ **Yes** ☐ **No**

5. Do you or your spouse work?

☐ **Yes** ☐ **No**

Please choose the name of a Primary Care Physician (PCP):

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format: ☐ **Large Print** ☐ **Other** _____

Please contact HealthTeam Advantage at 888-965-1965, if you need information in another accessible format or language other than what is listed above. Our office hours are 8 am to 8 pm, seven days a week (EST) from October 1st to March 31st, and 8 am to 8 pm Monday through Friday, from April 1st to September 30th. TTY users should call 711.

Please Read This Important Information

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

Please Read and Sign Below

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

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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.

HealthTeam Advantage serves a specific service area. If I move out of the area that HealthTeam Advantage 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 HealthTeam Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from HealthTeam Advantage 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 HealthTeam Advantage coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, HealthTeam Advantage provides refunds for all covered benefits, even if I get services out of network. Services authorized by HealthTeam Advantage and other services contained in my HealthTeam Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HealthTeam Advantage 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 HealthTeam Advantage he/she may be paid based on my enrollment in HealthTeam Advantage.

Release of Information: By joining this Medicare health plan, I acknowledge that HealthTeam Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that HealthTeam Advantage 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.

Signature:	**Todays Date:**

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

Name: _____ Relationship to Enrollee: _____

Address: _____ Phone Number: _____

Office Use Only:

Name of agent/broker (if assisted in enrollment): _____ NPN Number: _____

Plan ID#: _____ Effective Date of Coverage: _____

Date Application Received by Agent: _____

ICEP/IEP: _____ AEP: _____ OEP: _____ SEP (type): _____ Not Eligible: _____