EmblemHealth®

GROUP

To Enroll in EmblemHealth Medicare HMO, Please Provide the Following Information:

Select Plan ☐ **VIP Premier (HMO)**

Other plan name: _____ Option# (if required): _____

EMPLOYER INFORMATION

Employer Name:	Group#:
Employer Signature (if applicable):	
Subscriber Name of Employee/Retiree (if different from applicant):	

Last Name:	First Name:	M.I. ☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: ____/____/_____	Sex: ☐ M ☐ F	Home Phone Number: ( ) _____-_____
Permanent Address (No PO Boxes):		
City:	State:	ZIP Code:
Mailing Address (only if different from Permanent Address):		
City:	State:	ZIP Code:
Emergency Contact:	**Phone Number:**	**Relationship to you:**
E-mail Address:		

Please Provide Your Medicare Insurance Information

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.

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

MEDICARE HEALTH INSURANCE

1-800-MEDICARE

Name: _____

Medicare Claim Number Sex ___

__ __ __ - __ __ - __ __ __ __ ___

Is Entitled To	Effective Date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

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86-5849

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 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 don't need regular dialysis any more, please attach a note or records from your doctor showing you had a successful kidney transplant or you don't 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 this plan? ☐ Yes ☐ No
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: _____

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 and phone number of institution (number and street): _____

7. Are you enrolled in your state Medicaid program? ☐ Yes ☐ No
If "yes," please provide your Medicaid number or copy of current award letter: _____

8. The EmblemHealth Medicare HMO provider directory is available in an online format at www.emblemhealth.com.
Please check here if you would prefer to use the online provider directory rather than receiving a paper edition. ☐
Please note that at any time you can contact Customer Service for a paper edition.
Please choose the name of a Primary Care Physician (PCP) from our Provider Plan Directory.
(if required): NAME_____ PCP #_____
Current Patient ☐

Race/Ethnic Affiliation: (optional)
☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ American Indian
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other _____

Please check one of the boxes below if you would prefer us to send you information in a language other than English. ☐ Spanish ☐ Chinese

*Please contact EmblemHealth Medicare HMO at **1-800-447-8255** if you need information in another format or language than what is listed above. TTY users should call **1-888-447-4833**. Our office hours are from 8 am to 8 pm, 7 days a week (TTY users from 8 am to 5 pm, 7 days a week).*

Marital Status: ☐ Single ☐ Married ☐ Widow(er) ☐ Other _____

Power of Attorney, Conservator, Guardian: (please choose one if applicable)
☐ Power of Attorney ☐ Conservator ☐ Guardian ☐ None

Name: **Phone#:** (_____) _____ _____

Please Read and Sign on Reverse

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

Health Insurance Plan of Greater New York/EmblemHealth Medicare 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 only be in 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 do not 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: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

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

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 EmblemHealth Medicare HMO 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 state law 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.

Your Signature:	
Proposed Effective Date:	**Today's Date:**

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

Name: _____

Address: _____

Phone Number: (_____) _____- _____ **Relationship to Enrollee:** _____

For Company Use Only

Staff Member/Agent/Broker Signature: _____

Plan ID: _____ Manager ID:_____

Source Code: _____

Election Period: ICEP/IEP: _____ AEP: _____ SEP (type): _____

HIP Health Plan of New York (HIP) is a Medicare Advantage organization with a Medicare contract

Group Health Incorporated (GHI), HIP Health Plan of New York (HIP), HIP Insurance Company of New York (HIPIC) and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.