



Please contact AlohaCare Advantage/AlohaCare Advantage Plus if you need information in another language or format (Braille).

**To Enroll in AlohaCare Advantage (HMO)/AlohaCare Advantage Plus (HMO),  
Please Provide the Following Information:**

**Please check which plan you want to enroll in:**

AlohaCare Advantage (HMO)  AlohaCare Advantage Plus (HMO)

LAST Name: \_\_\_\_\_ FIRST Name: \_\_\_\_\_ Middle Initial \_\_\_\_\_  Mr.  Mrs.  Ms.

Birth Date: (__ __/__/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ( ) ( )	Alternate Phone Number: ( ) ( )
--	---	-------------------------------	------------------------------------

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

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

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

Street 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.



SAMPLE ONLY

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

Medicare Claim Number \_\_\_\_\_ Sex \_\_\_\_\_

\_\_\_\_ - \_\_\_\_ - \_\_\_\_

Is Entitled To \_\_\_\_\_ Effective Date \_\_\_\_\_

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

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

## Paying Your Plan Premium

**If we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail 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

Automatic deduction from your monthly Social Security benefit 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 to the point withholding begins.)

### **Please read and answer these important questions:**

1. Do you have End-Stage Renal Disease (ESRD)?  Yes  No

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 records** 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.

Will you have other prescription drug coverage in addition to AlohaCare Advantage/AlohaCare Advantage Plus?  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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. 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 & Phone Number of Institution (number and street): \_\_\_\_\_

4. Are you enrolled in your State Medicaid program?  Yes  No

If yes, please provide your Medicaid number: \_\_\_\_\_

5. Do you or your spouse work?  Yes  No

**Please choose the name of a Primary Care Physician (PCP), clinic or health center:**

**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:**

Oral Translation (English)

Large Print (English)

Please call our Customer Service Department at 973-6395 from Oahu or toll free at 1-866-973-6395 from the Neighbor Islands and the Mainland, Monday through Friday, from 8 a.m. to 8 p.m., Hawaii Standard Time, or if you need information in another format or another language than what is listed above. Or visit us Monday through Friday, 8 a.m. to 5 p.m. TTY/TDD users should call 1-877-477-5990.



**Please Read This Important Information**

**If you currently have health coverage from an employer or union, joining AlohaCare Advantage/AlohaCare Advantage Plus could affect your employer or union health benefits.** You could lose your employer or union health coverage if you join AlohaCare Advantage/AlohaCare Advantage Plus. 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:**

AlohaCare Advantage/ AlohaCare Advantage Plus 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. 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.

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

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

<b>Signature:</b> _____	<b>Today's Date:</b> _____
-------------------------	----------------------------

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

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

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

**Phone Number:** (\_\_\_\_) \_\_\_\_ - \_\_\_\_

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

**Office Use Only:**

Name of staff member/agent/broker (if assisted in enrollment): \_\_\_\_\_

Plan ID #: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

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

**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 of each year, as long as you don't add or drop your prescription drug coverage.** *(i.e. if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage you can only change to another plan without Medicare 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. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare.
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) \_\_\_\_\_.
- I have both Medicare and Medicaid or my state helps pay for my Medicare Premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) \_\_\_\_\_.
- I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) \_\_\_\_\_.
- I recently left a PACE program on (insert date) \_\_\_\_\_.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) \_\_\_\_\_.
- I am leaving employer or union coverage on (insert date) \_\_\_\_\_.
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) \_\_\_\_\_.
- None of these statements applies to me.\*

\*Please contact AlohaCare Advantage/AlohaCare Advantage Plus at 973-6395 from Oahu or toll-free at 1-866-973-6395 from the Neighbor Islands and the Mainland (TTY/TDD users should call 1-877-447-5990) to see if you are eligible to enroll. We are open Monday through Friday, 8 a.m. to 5 p.m.