

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

**To Enroll in Capital Health Plan in 2011,  
Please Provide the Following Information:**



**Capital Health**  
P L A N



AN INDEPENDENT MEMBER OF THE  
Blue Cross and Blue Shield Association

Employer Name:	Group #:
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LAST Name:	FIRST Name:	Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date: ( _ _ / _ _ / _ _ ) (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: (    )	Alternate Phone Number: (    )
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Permanent Residence Street Address (P.O. Box is not allowed):

City:	State:	ZIP Code:	County:
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**Mailing Address** (only if different from your Permanent Residence Address):

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

**E-mail Address** (optional): \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_


**Phone Number:** \_\_\_\_\_ **Relationship to You:** \_\_\_\_\_

**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.

	
<b>MEDICARE HEALTH INSURANCE</b>	
Name: _____	
Medicare Claim Number	Sex _____
_____ - _____ - _____	_____
Is Entitled To	Effective Date
<b>HOSPITAL (Part A)</b>	_____
<b>MEDICAL (Part B)</b>	_____

**Please read and answer these important questions**

1. Are you the retiree?  Yes  No

If yes, what is/was your retirement date? (month/date/year): \_\_\_\_\_

If no, what is the retiree's name?: \_\_\_\_\_ Retirement Date: \_\_\_\_\_

2. If you are the retiree, 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 answered "yes" to this question and you don't need regular dialysis any more, or 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.

5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to CHP?  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 & Phone Number of Institution (number and street): \_\_\_\_\_

7. Do you receive Medicaid benefits?  Yes  No

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

8. Please choose a primary care physician. \_\_\_\_\_

Are you an established patient of this primary care physician?  Yes  No

Please contact Capital Health Plan at 850-523-7441 (TTY users should call 850-383-3534) seven days a week, 8 a.m. to 8 p.m. if you need information in another format or language other than English.

**Please Read and Sign Below**

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

Capital Health Plan Retiree Advantage (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. 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 if an enrollment period is available (Example: Annual Enrollment Period from October 15<sup>th</sup> – December 7<sup>th</sup>, or under certain special circumstances.

Capital Health Plan Retiree Advantage serves a specific service area. If I move out of the area that Capital Health Plan Retiree 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 Capital Health Plan Retiree 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 Capital Health Plan Retiree Advantage when I get it to know which rules I must follow in order 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 Capital Health Plan Retiree Advantage coverage begins, I must get all of my health care from Capital Health Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Capital Health Plan and other services contained in my Capital Health Plan Retiree Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR CAPITAL HEALTH PLAN 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 Capital Health Plan, he/she may be paid based on my enrollment in Capital Health Plan. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.

**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 Capital Health Plan 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 Capital Health Plan or by Medicare.

**Signature:** \_\_\_\_\_

**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** \_\_\_\_\_

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

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) \_\_\_\_\_.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- None of these statements applies to me. \*

\*Please contact Capital Health Plan at 850-523-7441 (TTY users should call 850-383-3534) to see if you are eligible to enroll. We are available 8 a.m. to 8 p.m. seven days a week.

**Office Use Only**

Name of Staff Member (if assisted in enrollment): \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_ Plan ID #: \_\_\_\_\_

**Election Type:**

IEP(E): \_\_\_\_\_ ICEP(I): \_\_\_\_\_ Dual/LIS SEP(U): \_\_\_\_\_ Perm Chg in Res(V): \_\_\_\_\_

EGHP SEP(W): \_\_\_\_\_ Admin. SEP(X): \_\_\_\_\_ CMS/Case Worker SEP(Y): \_\_\_\_\_

OEPI(T): \_\_\_\_\_ Other SEP (S): \_\_\_\_\_ AEP(A): \_\_\_\_\_

Received Application:

Called Member:

Processed in System:

Submitted to CMS: