

# Medicare Advantage Group HMO Application for Enrollment



Health Alliance Plan  
2050 W. Grand Blvd., Detroit, MI 48202  
Telephone (313)664-7015  
A non-profit Corporation

To Enroll in HAP Senior Plus, Please Provide the Following Information:

EMPLOYER Name: \_\_\_\_\_ GROUP Number: \_\_\_\_\_

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

Birth Date: (__/__/____) M / D / Y Y Y Y	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number (providing this information is optional)	Home Phone Number: (__ ) _____
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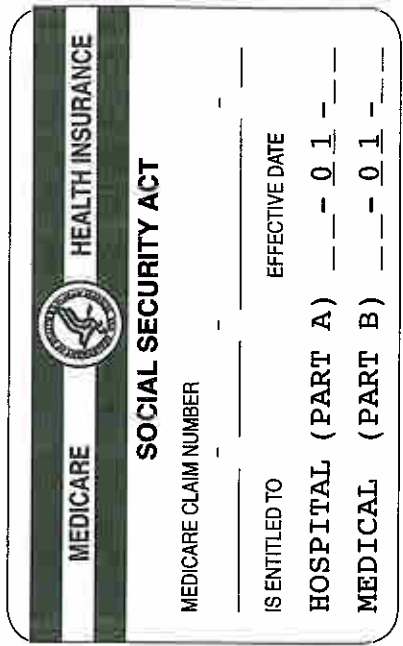
Permanent Residence Address: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

City: \_\_\_\_\_

Mailing Address (if different from permanent address)  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

### Please Provide the Following 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 the Social Security Administration or Railroad Retirement Board.
- You must have Medicare Part A and Part B to join a Medicare Advantage plan.



### 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 no, 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 do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not 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 HAP Senior 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 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:  
Please choose the name of chosen Primary Care Physician (PCP), clinic or health center (if required): \_\_\_\_\_

**Please Read and Sign Below:**

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

HAP Senior Plus is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. 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. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to HAP Senior Plus or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

HAP Senior Plus serves a specific service area. If I move out of the area that HAP Senior 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 HAP Senior Plus, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from HAP Senior Plus when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

I understand that beginning on the date HAP Senior Plus coverage begins, I must get all of my health care from HAP Senior Plus, with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico. Services authorized by HAP Senior Plus and other services contained in my HAP Senior Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HAP SENIOR PLUS WILL PAY FOR THE SERVICES.**

**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. 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 behalf of the individual under the laws of the State where the individual resides) 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 HAP Senior Plus or by Medicare.

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

**Today's Date:** \_\_\_\_\_

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

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

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

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

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

**Office Use Only:**

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

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

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

ICEP/IEP: \_\_\_\_\_ OEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP (type): \_\_\_\_\_