NEW WEST MEDICARE

Montana University System Medicare Advantage Plan (MUSMAP)

New West Medicare Employer Group Health Plan (PPO) Enrollment Request Form

To Enroll in the MUSMAP Plan, please provide the following information:			
Employer or Union Name:		**Campus:**	
LAST name:	FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: __ __ / __ __ / __ __ __ __ (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ 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): Address: _____ City: _____State: _____ ZIP Code:_____			
E-mail Address: *(optional)*			

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.

Name: _____

Medicare Claim Number Sex _____

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

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

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 under this employer or union plan?** ☐ Yes ☐ No
   If yes, name of spouse: _____

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 have 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, Worker's Compensation, VA benefits or State pharmaceutical assistance programs.
   Will you have other <u>prescription</u> drug coverage in addition to this New West Medicare Employer Group 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 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): _____

Please check one of the boxes below if you would prefer us to send you information in another format:
____ Large print ____ Braille

Please contact Customer Service at (888) 873-8049 if you need information in another format than what is listed above or in another language. Our office hours are Monday through Friday, 8:00 a.m. – 8:00 p.m.; alternative technologies may be used for weekends and holidays. TTY users should call (888) 290-3658.

Please Read and Sign Below

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

This New West Medicare Employer Group Plan 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 any other Medicare health plan. It is my responsibility to inform you of any medical or 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, or under certain special circumstances, by contacting my Human Resources Department.

This New West Medicare Employer Group Plan serves the State of Montana. If I move out of the state, I need to notify my Human Resources Department so I can disenroll and find a new plan in my new area. Once I am a member of this New West Medicare Employer Group Plan, I have the right to appeal plan decisions

about payment or services if I disagree. I will read the Group Evidence of Coverage and Summary of Benefits documents from New West Medicare when I receive them to know which rules I must follow to get coverage with this 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 MUSMAP coverage begins, I must get all of my health care from this New West Medicare Employer Group Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by New West Medicare and other services contained in the New West Medicare Group Evidence of Coverage (also known as a member contract or subscriber agreement) and my MUSMAP Summary of Benefits documents will be covered. Without authorization, **NEITHER MEDICARE NOR THIS NEW WEST MEDICARE EMPLOYER GROUP 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 New West Medicare, he/she may be paid based on my enrollment in the 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 New West Medicare 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: _____ **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: _____

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: _____

H2701_NW# 855G-03-12