NEW WEST MEDICARE
. . . Medicare Simplified

Montana University System
Medicare Advantage Pilot Plan (MAPP)
Employer Group Health Plan Enrollment Form

To Enroll in the Montana University System Medicare Advantage Pilot Plan, please provide the following information:

Employer Name: Montana University System		Campus:	
LAST name:	**FIRST Name:**	**Middle Initial**	Mr. Mrs. Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: M F	**Social Security Number:** *(providing this information is optional)*	Home Phone Number: ( )
Permanent Residence Street Address:			
City:	**State:**	**ZIP Code:**	
Mailing Address (only if different from your Permanent Residence Address):			
Street Address:	**City:**	**State:**	**ZIP Code:**
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 the Social Security Administration or 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) _____

Please read and answer these important questions

1. **Are you the MUS retiree?** Yes No

If yes, retirement date (month/date/year): _____

If no, name of retiree: _____

2. **Do you or your spouse work? Yes No**

If **yes**, are you covered under the employer's group health plan: **Yes No**

If **yes**, please provide the policy number and contact information for the plan: _____

3. **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.

4. 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 the MAPP benefits provided by New West?
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:

5. **Are you a resident in a long-term care facility, such as a nursing home? Yes No**

If "**yes**" please provide the Name of the Institution: _____

Address & Phone Number of Institution (number and street):_____

6. **Do you receive Medicaid benefits? Yes No**

If **yes**, please provide your Medicaid number:

Please Read and Sign Below

<u>By completing this enrollment application, I agree to the following:</u>

MUS MAPP is a Medicare Advantage Employer Group Health Plan and I will need to keep my Medicare 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. 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. I may leave this plan only at certain times of the year, or under certain special circumstances, by contacting my former campus Human Resources Department.

MUS MAPP 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 MUS MAPP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage and Summary of Benefits documents from New West Medicare when I receive them to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that I am not covered under this plan while out of the country except for limited circumstances outlined in the Evidence of Coverage and Summary of Benefits.

<u>Release of Information:</u> By joining the MUS MAPP Medicare Advantage Employer Group 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 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 New West Medicare 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): _____ Not Eligible: _____

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