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:

Please contact New West Medicare if you need information in another language or format (Large Print)

Employer: 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	Home Phone Number: ( )	Social Security Number: *(providing this information is optional)*
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:			
E-mail Address: _____	**Alternate Phone Number: ( ) _____**		

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) _____

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 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.

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 Medicare (PPO)? □ 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 following information:

Name of Institution: _____

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

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

If yes, please provide your Medicaid ID 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 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 only at certain times of the year, or under certain special circumstances, by contacting my campus Human Resources ~~Department .~~<u>Department.</u>

MUS MAPP serves the State of Montana. If I move out of the state permanently, 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 (PPO) when I receive them to know which rules I must follow to get coverage with this Medicare Advantage plan.

I understand that beginning on the date MUS MAPP coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, MUS MAPP provides refunds at the Medicare allowed amounts for all covered benefits, even if received out-of- network. Services authorized by MUS MAPP and other services contained in my MUS MAPP Evidence of Coverage and the Summary of Benefits documents will be covered. Without authorization, **NEITHER MEDICARE NOR NEW WEST MEDICARE (PPO) 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 MUS MAPP, he/she may be paid based on my enrollment in MUS MAPP.

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 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 (PPO) 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 New West Medicare (PPO) or by Medicare.

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/agent/broker (if assisted in enrollment): _____
Plan ID #: _____
Effective Date of Coverage: _____
ICEP/IEP:_____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____