

1 Enrollment Request Form—Personal Information

Arizona SNP* (Eligibility Requirements) 001 Maricopa County \$0 per month
Arizona MAPD 002 Maricopa County \$0 per month

Please print your last name, first name, and middle initial exactly as it appears on your Medicare card.

Social Security Number (Optional) - Birth Date Male Female

Name: Last First M.I.

Home Address Apt. # County

City State Zip Telephone ()

Mailing Address (if different from above) Apt.# County

City State Zip Telephone ()

Name of Person to Contact in Case of Emergency (Optional)

Address

Telephone () Relationship

Your answers to these following questions **WILL NOT** keep you from enrolling in this plan.

Race/Ethnicity: African American/Black
 American Indian or Alaska Native Asian Caucasian Hispanic
 Native Hawaiian or Other Pacific Islander Declined to State Other: _____

Marital status: Married Single Divorced Widowed

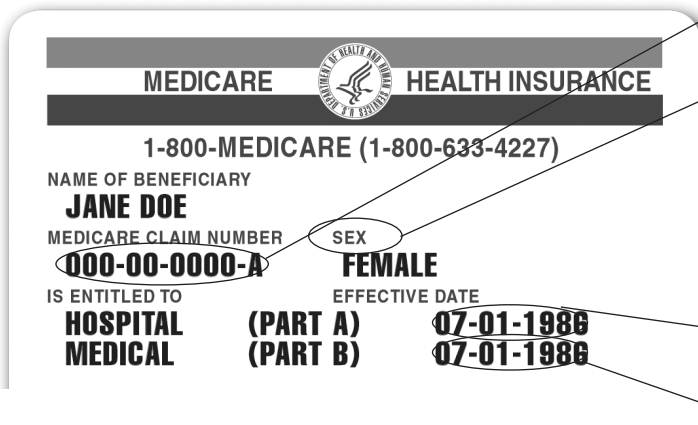
Preferred written language: English Spanish Braille Other formats: _____

Preferred spoken language: English Spanish Sign language/TTY Other formats: _____

E-mail address:

2 Medicare Information

Please fill in the blanks below with the information exactly as it appears on your Medicare card. You must either fill this out, or you can attach a copy of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board.

	Name	<input type="text"/>
	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/>
	Medicare Claim Number	<input type="text"/>
	Is Entitled To:	<input type="text"/>
	Hospital Insurance (Part A) Effective Date: _____	<input type="text"/>
	Hospital Insurance (Part B) Effective Date: _____	<input type="text"/>

3 Arizona Long Term Care (ALTCS) Information

Please provide your ALTCS information. *You must be enrolled in ALTCS to be eligible for the Arizona SNP.

ALTCS Member ID Number:

Program Contractor:

4 Primary Care Physician (PCP) Information

To choose a doctor, refer to your Physician and Hospital Directory for a list of physicians. (Optional)

PCP Name:

Is this a new physician for you? Yes No

5 | Late Enrollment Penalty

If we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail each month. You can also choose to pay your late enrollment penalty by automatic deduction from your Social Security Check each month.

Please select a payment option:

- Receive a bill.
- Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment date up to the point withholding begins.)

6 | Medical Information

1. 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 had a successful kidney transplant.
2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.
Will you have other prescription drug coverage in addition to SCAN? 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: _____
3. Are you a resident in a long-term care facility, such as a nursing home? Yes No
If "yes," name of institution: _____ Date of admission: / /
Address: _____ Telephone () _____
4. Are you enrolled in Arizona Health Cost Containment System (AHCCCS)? Yes No
If "yes," please provide your Medicaid number: _____
5. Do you or your spouse work? Yes No

7 | Please Read This Important Information

If you currently have health coverage from an employer or union, joining SCAN could affect your employer or union health benefits. If you have health coverage from an employer or union, joining SCAN may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their web site, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

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, including the Statement of Understanding. 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 SCAN or by Medicare.

8 | Signature

Please sign here*	Date
If you are the authorized representative or a witness/translator, you must provide the following information:	
Name: _____	Relationship to Enrollee: _____
Address: _____	Telephone () _____
*If the individual cannot sign, a court appointed Legal Guardian or designee assigned in a written advance directive, if authorized by state law, must sign below. Attach a copy of proof of Legal Guardianship, written advance directive, or proof of authorization by state law.	
Signature _____	Date _____

OFFICE USE ONLY	NAME OF STAFF MEMBER (if assisted in enrollment)	REP. CODE
EFFECTIVE DATE OF COVERAGE / /	ICEP/IEP: ____ OEP: ____ AEP: ____ SEP (type): ____ Not Eligible: _____	

STATEMENT OF UNDERSTANDING

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

I understand that while the “effective date of coverage” on the first page of this form is when I should begin using the plan’s services, the plan will still be sending me final approval of my enrollment in SCAN®.

I understand that I should not disenroll from any **Medicare supplement plan, Medigap or Medicare Select plan** until I get the approval from SCAN.

I understand that I will be responsible for paying the plan premium within the county where I live.

SCAN is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Parts A and B. I can be in only 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 or prescription drug plan. It is my responsibility to inform SCAN 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. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: November 15–December 31 of every year), or under certain special circumstances.

SCAN serves a specific service area. If I move out of the area that SCAN 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 SCAN, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from SCAN when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. *I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.*

Lock-In: I understand that, beginning on the date my SCAN coverage begins, I must get all of my health care from SCAN, with the exception of emergency or urgently needed services or out-of-area dialysis services. In addition to being covered in the United States, emergency and urgently needed services

are covered worldwide. I understand that services authorized by SCAN and other services contained in my SCAN Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. I also understand that without authorization, **NEITHER MEDICARE NOR SCAN WILL PAY FOR THE SERVICES.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with SCAN, he/she may be compensated based on my enrollment in SCAN.

RELEASE OF INFORMATION

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other parties as is necessary for treatment, payment and health care operations. *I also acknowledge that SCAN 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 agree to abide by the plan’s membership rules as outlined in SCAN’s Evidence of Coverage. I will read SCAN’s Evidence of Coverage to know what rules I must follow in order to receive coverage with this plan as well as any exclusions and limitations that may apply.

Step 1: Please fill out the application completely. Use a ballpoint pen and press hard to make three copies.



Step 2: Read the Statement of Understanding and keep it for your records.

Step 3: Sign and date the bottom of the application.

Step 4: Keep the bottom BLUE copy for your file.

If you have any questions regarding this application, please call 1-866-563-7396, 8 A.M.–8 P.M., 7 days per week, (TTY users: 1-800-367-8939, 8 A.M.–8 P.M., 7 days per week).