

# Individual Enrollment Request Form

Please contact SCAN® Health Plan if you need information in another language or format (Braille).

## 1 To Enroll in SCAN Health Plan, Please Provide the Following Information:

**SCAN San Joaquin County** (Please check which plan you want to enroll in)

001 Gold \$0 per month       002 Gold Select \$0 per month       003 Silver \$0 per month

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Mr./Mrs./Ms.

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Sex:  Male  Female Home Phone #: (\_\_\_\_) \_\_\_\_\_

Permanent Residence Street Address (PO Box is not allowed): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing Address (only if different from your Permanent Residence Address): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Emergency Contact (optional): \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

Preferred Written Language:  English  Spanish  Braille  Other Formats \_\_\_\_\_

Preferred Spoken Language:  English  Spanish  Sign Language/TTY  Other Formats \_\_\_\_\_

Please contact SCAN at **1-800-539-3500** if you need information in another format or language than what is listed above. Our office hours are 7:00 A.M. – 8:00 P.M., 7 days per week. TTY users should call 1-800-735-2929.

E-mail Address (optional): \_\_\_\_\_

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

Race/Ethnicity: (Please use codes from Race/Ethnicity Ledger)  African American/Black \_\_\_\_\_

American Indian or Alaska Native \_\_\_\_\_  Asian \_\_\_\_\_  Caucasian \_\_\_\_\_  Hispanic \_\_\_\_\_

Native Hawaiian or Other Pacific Islander \_\_\_\_\_  Decline to State  Other \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed

## 2 Physician Information

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

Physician Name	Physician ID Number
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Medical Group Name	Group ID Number
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Is this a new physician for you?  Yes  No

## 3 Please Provide Your Medical 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): \_\_\_\_\_

## 4 | Paying Your Plan Premium

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

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at [www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.gov/prescriptionhelp).

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

### **Please select a premium payment option:**

- Get 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 effective date up to the point withholding begins.)

## 5 | Please Read and Answer These Important Questions

1. 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 if you 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.

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 Health 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 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," please provide the following information:

Name & Address of Institution: \_\_\_\_\_

4. Are you enrolled in a Medi-Cal program?  Yes  No  
If "yes," please provide your Medi-Cal number: \_\_\_\_\_

5. Do you or your spouse work?  Yes  No

## 6 | Please Read This Important Information

If you currently have health coverage from an employer or union, joining SCAN Health Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join SCAN Health Plan. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

## 7 | Please Read and Sign Below

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

SCAN Health 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 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 you of any prescription drug coverage that I have or may get in the future. If I have selected the Silver Plan (MA Only Plan), I understand that if I *don't* 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 Health Plan serves a specific service area. If I move out of the area that SCAN Health Plan 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 get it to know which rules I must follow to get coverage with this Medicare Advantage 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 SCAN coverage begins, I must get all of my health care from SCAN, except for emergency or urgently needed services or out-of-area dialysis services. 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. Without authorization, **NEITHER MEDICARE NOR SCAN 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 SCAN, he/she may be paid based on my enrollment in SCAN.

**Release of Information:** By joining this Medicare health plan, I acknowledge that SCAN will release my information to Medicare and other plans 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 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 SCAN Health Plan or by 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: \_\_\_\_\_

**INFORMATION TO INCLUDE ON OR WITH ENROLLMENT MECHANISM—ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD**

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you don't add or drop your prescription drug coverage (i.e. if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage you can only change to another plan without Medicare prescription drug coverage). Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare.
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date): \_\_\_\_\_
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date): \_\_\_\_\_
- I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date): \_\_\_\_\_
- I recently left a PACE program on (insert date): \_\_\_\_\_
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date): \_\_\_\_\_
- I am leaving employer or union coverage on (insert date): \_\_\_\_\_
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) \_\_\_\_\_
- None of these statements applies to me.\*

\* Please contact SCAN Health Plan at 1-800-699-7689 (TTY users should call 1-800-735-2929) to see if you are eligible to enroll. We are open 8:00 A.M.–8:00 P.M., 7 days per week.

<b>OFFICE USE ONLY</b>		NAME OF STAFF MEMBER/AGENT/BROKER: (if assisted in enrollment)				DATE:
EFFECTIVE DATE OF COVERAGE / /	ICEP/IEP:	OEP:	AEP:	SEP (TYPE):	NOT ELIGIBLE:	REP. CODE:

3800 Kilroy Airport Way, Suite 100, Long Beach, CA 90806

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

**Step 2:** Sign and date the application.

**Step 3:** Keep the BOTTOM copy for your file.

If you have any questions regarding this application, please call 1-800-699-7689, 8:00 A.M.–8:00 P.M., 7 days per week (TTY users: 1-800-735-2929, 8:00 A.M.–8:00 P.M., 7 days per week).

## Race/Ethnicity Ledger Codes:

Race/Ethnicity Category	Sub-Category	Code
<b>African American/Black</b> <i>If not African American or African,                      Select "Black/African American" only</i>	African American	B1
	African	B2
<b>American Indian or Alaska Native</b> <i>If not from a California Tribe, select "American Indian" only</i>	California Tribes	I1
<b>Asian</b> <i>If not from an Asian sub-category that is listed,                      select "Asian" only</i>	Asian Indian	A1
	Cambodian	A2
	Chinese	A3
	Filipino	A4
	Korean	A5
	Laotian	A6
	Japanese	A7
	Thai	A8
	Vietnamese	A9
<b>Caucasion/White</b>	European	C1
	Middle East & North African	C2
	Arab	C3
<b>Hispanic or Latino/a</b> <i>If not from a Hispanic or Latino/a sub-category that is listed,                      select "Hispanic or Latino/a" only</i>	Mexican	H1
	Mexican American Indian	H2
	Central American	H3
	South American	H4
	Puerto Rican	H5
	Cuban	H6
<b>Native Hawaiian or Other Pacific Islander</b> <i>If not from a sub-category listed above, select "Native                      Hawaiian or Other Pacific Islander"</i>	Native Hawaiian	N1
	Samoaan	N2
	Guamanian	N3