BayCarePlus™
Medicare Advantage

Please contact BayCare Health Plans (HMO) Sales at (866) 947-5820 if you need assistance completing this form. TTY users may call 711 toll free.

TO ENROLL IN A BayCarePlus PLAN, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Please check which plan you want to enroll in:

☐ BayCarePlus Complete – (Hillsborough, Pasco, Pinellas and Polk Counties) - $0 per month

☐ BayCarePlus Rewards – (Hillsborough, Pasco, Pinellas and Polk Counties) - $0 per month

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):			County:
City:		State:	ZIP Code:
Mailing Street Address (only if different from your Permanent Residence Address):			
City:		State:	ZIP Code:
E-mail Address (optional):			
Emergency Contact:		Phone Number:	
Relationship to You:			

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please take out your red, white, and blue Medicare card to complete this section:

- Fill out the information as it appears on your 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 (as it appears on your Medicare card):

Medicare Number:

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Is Entitled To	Effective Date:
Hospital (Part A)	__ __ / __ __ / __ __ __ __
Medical (Part B)	__ __ / __ __ / __ __ __ __

PAYING YOUR PLAN PREMIUM

If you enroll in a zero premium plan: If we determined that you owe a late enrollment penalty, (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check, or check via mail. If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration (SSA). You will be responsible for paying this extra amount in addition to your monthly charges. You will either have the amount withheld from your SSA benefit check or be billed directly by Medicare or the RRB. DO NOT pay BayCare Health Plans the Part D-IRMAA.

If you enroll in a plan with a premium: You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check, each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the SSA. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay BayCare Health Plans the Part D-IRMAA.

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 coinsurance. 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.

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 monthly bill

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board benefit check.

I get monthly benefits from : ___Social Security ____RRB

The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

1 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.

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 BayCare Health Plans? ☐ 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 of institution:_____

Address and phone number of institution (number and street):

_____

4 Are you enrolled in your state Medicaid program? ☐ Yes ☐ No

If "yes," please provide your Medicaid number:_____

5 Do you or your spouse work? ☐ Yes ☐ No

PLEASE CHOOSE THE NAME OF A PRIMARY CARE PHYSICIAN

Primary Care Provider (PCP):	PCP # from Provider Directory:	Is this your current physician?
Dr. _____ (First Name) (Last Name)	☐☐☐☐☐☐☐☐☐☐	☐ Yes ☐ No

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

☐ Spanish ☐ German ☐ Chinese ☐ French ☐ Vietnamese
☐ Braille ☐ Large Print

Please contact BayCare Health Plans at (866) 947-5820 if you need information in another format or language than what is listed above. Our office hours are 8am to 8pm seven days a week. You may reach a messaging service on weekends and holidays from April 1 through September 30. TTY users should call 711 toll free.

STOP PLEASE READ THIS IMPORTANT INFORMATION STOP

If you currently have health coverage from an employer or union, joining BayCare Health Plans could affect your employer or union health benefits. You could lose your employer or union health coverage if you join BayCare Health Plans. 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.

PLEASE READ AND SIGN BELOW

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

BayCare Health Plans 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. 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: October 15 – December 7 of every year), or under certain special circumstances.

BayCare Health Plans serves a specific service area. If I move out of the area that BayCare Health Plans 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 BayCare Health Plans, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from BayCare Health Plans 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 my BayCare Health Plans coverage begins, I must get all of my health care from BayCare Health Plans, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by BayCare Health Plans and other services contained in my BayCare Health Plans *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BAYCARE HEALTH PLANS 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 BayCare Health Plans, he or she may be paid based on my enrollment in BayCare Health Plans.

Release of Information: By joining this Medicare health plan, I acknowledge that BayCare Health Plans will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that BayCare Health Plans will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes that 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 BayCare Health Plans or by Medicare.

Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:

Name:	Relationship to Enrollee:	Phone Number:	
Address:	City:	State:	ZIP Code:

FOR OFFICE USE ONLY

Confirmation # (Quick Entry or Telephone Enroll):

Plan ID#:	**Effective Date of Coverage**:

Election Periods:	☐ **ICEP (I)**	☐ **IEP (E)**	☐ **2nd IEP (F)**	☐ **AEP (A)**	☐ **OEP**	☐ **OEPI (T)**

Special Election Periods: (Check all that apply)

SEP (S)

- ☐ SPAP
- ☐ Loss of SNP
- ☐ Retro Entitlement
- ☐ Involuntary Loss/Creditable Coverage
- ☐ Contract/Plan Non-Renewal
- ☐ Contract Violations
- ☐ Contract Term – Immediate
- ☐ Contract Term – MAO
- ☐ Contract Term – CMS
- ☐ CMS Sanction
- ☐ Not informed/Creditable Coverage
- ☐ Error/Federal Employee

SEP (V)

- ☐ Permanent Move

SEP (W)

- ☐ Gain or Loss of Employer Coverage

SEP (U)

- ☐ Dual Eligible
- ☐ Medicaid Loss
- ☐ Non-Dual with LIS
- ☐ Non-Dual LIS loss/Redeeming
- ☐ Non-Dual LIS loss/Determining

☐ **Not Eligible**

Producer Name:	**Producer NPN:**	**Application Receipt Date**:

BayCarePlus™
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Please return completed application to:

BayCare Health Plans
P.O. Box 12847
St. Louis, MO 63132

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