

# 2012 Individual Enrollment Form

## When you are ready to enroll



Contact your local insurance agent to help you choose the best plan for you and complete this individual enrollment form, **or**



Call an Erickson Advantage® insurance agent who can help you enroll over the phone. Toll-free: **1-800-989-1389**, TTY **711**, 8:30 a.m. – 5 p.m. local time, Monday – Friday.

Note: If you do not have an agent helping you enroll, please complete the enrollment form, sign and date it, and send the enrollment copy to: Erickson Advantage, P.O. Box 29650, Hot Springs, AR 71903-9973.

I understand the person who is discussing plan options with me is an insurance agent, broker or other person employed by or contracted with Erickson Advantage®. The person may be paid based on my enrollment in a plan.

**If you currently have health coverage through an employer or union, joining one of our plans could affect your employer or union health benefits. You could lose your employer or union health coverage if you join our plan.** Read the communications your employer or union sends you. If you have questions, visit their website or contact their office. If you can't find any contact information, your benefits administrator or the office that answers questions about your coverage can help.

Turn the page to enroll.



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**3. Your payment options (if applicable)**

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail Electronic Funds Transfer (EFT) each month or we will provide you a coupon book. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. 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 Erickson Advantage® 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 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, it is recommended you choose the coupon book or EFT option.

(If you do not select a payment option, you will receive a coupon book for the amount that Medicare doesn't cover. If you would like to set up EFT, please enclose a blank check with **VOID** written on the front.)

**Please select a premium payment option (choose only one):**

- Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check** *(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.)*
- Electronic Funds Transfer (EFT)** from your bank account each month.  
Enclose a **voided** check or provide the following:  
 Account Holder Name \_\_\_\_\_ Bank Routing Number \_\_\_\_\_  
 Bank Account Number \_\_\_\_\_ Account Type  Checking  Savings
- Coupon Book**

Enrollee's name \_\_\_\_\_

Proposed effective date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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**4. Benefit plan selections (choose only one)**

**Point of Service (HMO-POS) plans with a medical and Part D drug benefit**

- Erickson Advantage® Guardian (HMO-POS SNP)\* EG
- Erickson Advantage® Champion (HMO-POS SNP) EC
- Erickson Advantage® Signature with Drugs (HMO-POS) ESX

**HMO-POS plans with medical benefit only**

- Erickson Advantage® Signature without Drugs (HMO-POS) ES

\*I understand that to enroll in or to remain enrolled in the Erickson Advantage® Guardian (HMO-POS SNP) Plan I must live, or be expected to live, in a skilled nursing facility on an Erickson campus.

**Erickson Advantage® Specific Long Term Illness Special Needs Plan –  
Erickson Advantage® Champion (HMO-POS SNP)**

**Do you have any of the chronic illnesses listed below?**

- Diabetes Mellitus
- Chronic Heart Failure
- Cardiac Arrhythmia
- Peripheral Vascular Disease
- Coronary Artery Disease (CAD)
- Chronic Venous Thromboembolic Disorder

**5. Primary Care Physician (PCP), Clinic or Health Center Selection**

Refer to your Provider Directory or the Plan website to select a PCP.

Provider ID # \_\_\_\_\_

PCP name \_\_\_\_\_

Are you now seeing or have you recently seen this doctor?  Yes  No

Enrollee's name \_\_\_\_\_

Proposed effective date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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**6. Please read and answer these important questions**

**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.

If "yes," are you currently a member of a health care company?  Yes  No

If "yes," name of company \_\_\_\_\_ Member ID# \_\_\_\_\_

**Do you have any other prescription drug coverage such as private insurance, TRICARE, VA benefits, State Pharmaceutical Assistance Program or Federal Employee Health Benefits coverage?**  Yes  No Plan name of other coverage \_\_\_\_\_

Member ID# for this coverage \_\_\_\_\_

Group ID# \_\_\_\_\_ Effective Date (optional) \_\_\_\_\_

**Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)?**  Yes  No

If "yes," name of institution \_\_\_\_\_

Address of institution \_\_\_\_\_

City, State, ZIP Code \_\_\_\_\_

Phone number of institution (\_\_\_\_) \_\_\_\_\_ Date of admission to the institution \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Are you enrolled in your state Medicaid program?**  Yes  No

If "yes," please provide your Medicaid ID number \_\_\_\_\_

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

**Do you or your spouse have any health insurance other than Medicare, such as state insurance, Workers' Compensation or Veterans Administration (VA) benefits?**  Yes  No

If you have other health insurance, what kind do you have? \_\_\_\_\_

What is the name of the health insurance? \_\_\_\_\_

Group # \_\_\_\_\_ ID# \_\_\_\_\_

**7. Alternative formats (check only one)**

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

Spanish  Chinese  
 Large Print (English Only)  
 Other \_\_\_\_\_

Please contact Erickson Advantage® at 1-800-989-1389 if you need information in another format or language than those listed above. Our office hours are 8:30 a.m. – 5 p.m. local time, Monday – Friday. TTY users should call 711.

Enrollee's name \_\_\_\_\_

Proposed effective date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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**Statements of understanding**

1. Erickson Advantage<sup>®</sup> 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. For MA Only Plans, 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: October 15 – December 7 of every year), or under certain special circumstances.
2. I understand that to be eligible for Erickson Advantage<sup>®</sup> I must live in the service area. Service area is defined as residing in an Erickson community. If I move out of the service area, I must notify the Plan of the move and I will be disenrolled. I can, however, enroll in another Plan in my new service area. Once I am a member of Erickson Advantage<sup>®</sup>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Erickson Advantage<sup>®</sup> 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.
3. By joining this Medicare health plan, I acknowledge that Erickson Advantage<sup>®</sup> will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Erickson Advantage<sup>®</sup> 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.

Enrollee's name \_\_\_\_\_  
 Proposed effective date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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**Statements of understanding (cont.)**

4. I understand that if I previously had prescription drug coverage or any insurance that included drugs, I may be asked for proof that my previous prescription drug coverage was at least as good as Medicare's standard prescription drug coverage (creditable prescription drug coverage). I can send copies of my proof with this form or I can wait until I am asked for it. I don't have to send proof to enroll. However, if I am asked for my proof and I don't provide it, my premium may be increased because of a late-enrollment penalty. For more information about the late-enrollment penalty, I may visit [www.medicare.gov](http://www.medicare.gov) or 1-800-MEDICARE (1-800-633-4227); (hearing impaired users should call 1-877-486-2048), 24 hours a day, 7 days a week.
5. 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.
6. I understand that beginning on the date Erickson Advantage<sup>®</sup> Plan coverage begins, I must have services provided or arranged by my primary care physician except for emergency and urgently needed services and out-of-area renal dialysis. If I receive routine care that has not been arranged by my primary care team, I will access non-preferred benefits. Services authorized by Erickson Advantage<sup>®</sup> and other services contained in my Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **neither Medicare nor Erickson Advantage<sup>®</sup> will pay for the services.**
7. I understand that Medicare has special enrollment rules for the Erickson Advantage<sup>®</sup> Champion Plan. I understand that my Enrollment Form may be declined or I may be disenrolled for any of the following reasons:
  - I do not have a qualifying medical condition for enrollment in the Erickson Advantage<sup>®</sup> Champion Plan.
  - Erickson Advantage<sup>®</sup> is unable to confirm with my health care provider that I have a qualifying medical condition.
  - I apply for enrollment during a Special Enrollment Period determined by Medicare for individuals with a qualifying condition to enroll in Erickson Advantage<sup>®</sup>, but Erickson Advantage<sup>®</sup> cannot confirm that I have a qualifying condition.

**Fraud warning:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Enrollment Form or files a claim containing a false or a deceptive statement, has committed insurance fraud. Commission of insurance fraud may result in disenrollment or denial of benefits and may subject the individual to civil or criminal liability.

Enrollee's name \_\_\_\_\_  
 Proposed effective date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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**8. Please read this important information**

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 Enrollment Form means that I have read, understand and agree to the contents of this Enrollment Form, Statements of Understanding and the Additional Statement of Understanding (for the plan I have chosen) on this form.

**You must sign and date this Individual Enrollment Form in order for it to be processed.**

If signed by an authorized representative of the applicant, 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 Medicare.

Signature of applicant/member/authorized representative	Today's Date ____ / ____ / ____
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**If you are the authorized representative of the applicant, you must provide the following information and sign above.**

Name			Relationship to applicant
Address			Telephone Number (      )
City	State	ZIP Code	Alternate Phone Number (optional) (      )

**9. For sales representative/agency use only**

Selling Staff Member/Agent ID	Initial Receipt Date
Selling Staff Member/Agent Name	Proposed Effective Date
Agent Telephone Number	Did the agent assist in completing the application? <input type="checkbox"/> Yes <input type="checkbox"/> No
Agent Signature (required)	

**10. Election period**

AEP  
 ICEP  
 IEP (MA or MA-PD enrollees)  
 IEP (MA-PD enrollees eligible for 2nd IEP)  
 OEPI  
 SEP (SEP Reason Code \_\_\_\_\_ )

Enrollee's name \_\_\_\_\_  
 Proposed effective date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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Receipt

Important Enrollment Information

Application Date \_\_\_\_\_

Proposed Effective Date \_\_\_\_\_

Medicare ID \_\_\_\_\_

Plan Name \_\_\_\_\_

Health Plan/PBP Number \_\_\_\_\_

Insurance Agent ID \_\_\_\_\_

Insurance Agent Name \_\_\_\_\_

Insurance Agent Phone Number \_\_\_\_\_

I-Enroll Tracking Number (if applicable) \_\_\_\_\_

This copy verifies you met with an agent who sells Erickson Advantage,® administered by UnitedHealthcare,® products. Once UnitedHealthcare® receives the Enrollment Form, you will receive a copy of your original Enrollment Form in the mail within two weeks. This copy is for your records only. **Please do not resubmit.**

Please contact your insurance agent if you do not receive a copy of your original Enrollment Form in the mail within two weeks.



Talk to your local insurance agent for answers or to enroll.



If you do not have a local insurance agent, please call 1-800-989-1389, TTY 711, 8:30 a.m. – 5 p.m. local time, Monday – Friday.



Visit our website at: [www.EricksonAdvantage.com](http://www.EricksonAdvantage.com)



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**A UnitedHealthcare® Medicare Solution**

This information is available for free in other languages. Please contact our Erickson Advantage® Customer Service number at 1-800-989-1389, TTY/TDD: 711, 8:30 a.m. to 5 p.m. local time, Monday – Friday, for additional information.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro Servicio al Cliente de Erickson Advantage® al número 1-800-989-1389, TTY/TDD: 711, de 8:30 a.m. a 5 p.m. hora local, lunes – viernes, para obtener más información.

# 2012 Individual Enrollment Form

## When you are ready to enroll



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I understand the person who is discussing plan options with me is an insurance agent, broker or other person employed by or contracted with Erickson Advantage®. The person may be paid based on my enrollment in a plan.

**If you currently have health coverage through an employer or union, joining one of our plans could affect your employer or union health benefits. You could lose your employer or union health coverage if you join our plan.** Read the communications your employer or union sends you. If you have questions, visit their website or contact their office. If you can't find any contact information, your benefits administrator or the office that answers questions about your coverage can help.

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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, it is recommended you choose the coupon book or EFT option.

(If you do not select a payment option, you will receive a coupon book for the amount that Medicare doesn't cover. If you would like to set up EFT, please enclose a blank check with **VOID** written on the front.)

**Please select a premium payment option (choose only one):**

- Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check** *(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.)*
- Electronic Funds Transfer (EFT)** from your bank account each month.  
Enclose a **voided** check or provide the following:  
 Account Holder Name \_\_\_\_\_ Bank Routing Number \_\_\_\_\_  
 Bank Account Number \_\_\_\_\_ Account Type  Checking  Savings
- Coupon Book**

Enrollee's name \_\_\_\_\_  
 Proposed effective date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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**4. Benefit plan selections (choose only one)**

**Point of Service (HMO-POS) plans with a medical and Part D drug benefit**

- Erickson Advantage® Guardian (HMO-POS SNP)\* EG
- Erickson Advantage® Champion (HMO-POS SNP) EC
- Erickson Advantage® Signature with Drugs (HMO-POS) ESX

**HMO-POS plans with medical benefit only**

- Erickson Advantage® Signature without Drugs (HMO-POS) ES

\*I understand that to enroll in or to remain enrolled in the Erickson Advantage® Guardian (HMO-POS SNP) Plan I must live, or be expected to live, in a skilled nursing facility on an Erickson campus.

**Erickson Advantage® Specific Long Term Illness Special Needs Plan –  
Erickson Advantage® Champion (HMO-POS SNP)**

**Do you have any of the chronic illnesses listed below?**

- Diabetes Mellitus
- Chronic Heart Failure
- Cardiac Arrhythmia
- Peripheral Vascular Disease
- Coronary Artery Disease (CAD)
- Chronic Venous Thromboembolic Disorder

**5. Primary Care Physician (PCP), Clinic or Health Center Selection**

Refer to your Provider Directory or the Plan website to select a PCP.

Provider ID # \_\_\_\_\_

PCP name \_\_\_\_\_

Are you now seeing or have you recently seen this doctor?  Yes  No

Enrollee's name \_\_\_\_\_

Proposed effective date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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**6. Please read and answer these important questions**

**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.

If "yes," are you currently a member of a health care company?  Yes  No

If "yes," name of company \_\_\_\_\_ Member ID# \_\_\_\_\_

**Do you have any other prescription drug coverage such as private insurance, TRICARE, VA benefits, State Pharmaceutical Assistance Program or Federal Employee Health Benefits coverage?**  Yes  No Plan name of other coverage \_\_\_\_\_

Member ID# for this coverage \_\_\_\_\_

Group ID# \_\_\_\_\_ Effective Date (optional) \_\_\_\_\_

**Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)?**  Yes  No

If "yes," name of institution \_\_\_\_\_

Address of institution \_\_\_\_\_

City, State, ZIP Code \_\_\_\_\_

Phone number of institution (\_\_\_\_) \_\_\_\_\_ Date of admission to the institution \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Are you enrolled in your state Medicaid program?**  Yes  No

If "yes," please provide your Medicaid ID number \_\_\_\_\_

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

**Do you or your spouse have any health insurance other than Medicare, such as state insurance, Workers' Compensation or Veterans Administration (VA) benefits?**  Yes  No

If you have other health insurance, what kind do you have? \_\_\_\_\_

What is the name of the health insurance? \_\_\_\_\_

Group # \_\_\_\_\_ ID# \_\_\_\_\_

**7. Alternative formats (check only one)**

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

Spanish  Chinese  
 Large Print (English Only)  
 Other \_\_\_\_\_

Please contact Erickson Advantage® at 1-800-989-1389 if you need information in another format or language than those listed above. Our office hours are 8:30 a.m. – 5 p.m. local time, Monday – Friday. TTY users should call 711.

Enrollee's name \_\_\_\_\_

Proposed effective date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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**Statements of understanding**

1. Erickson Advantage<sup>®</sup> 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. For MA Only Plans, 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: October 15 – December 7 of every year), or under certain special circumstances.
2. I understand that to be eligible for Erickson Advantage<sup>®</sup> I must live in the service area. Service area is defined as residing in an Erickson community. If I move out of the service area, I must notify the Plan of the move and I will be disenrolled. I can, however, enroll in another Plan in my new service area. Once I am a member of Erickson Advantage<sup>®</sup>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Erickson Advantage<sup>®</sup> 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.
3. By joining this Medicare health plan, I acknowledge that Erickson Advantage<sup>®</sup> will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Erickson Advantage<sup>®</sup> 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.

Enrollee's name \_\_\_\_\_

Proposed effective date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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**Statements of understanding (cont.)**

4. I understand that if I previously had prescription drug coverage or any insurance that included drugs, I may be asked for proof that my previous prescription drug coverage was at least as good as Medicare's standard prescription drug coverage (creditable prescription drug coverage). I can send copies of my proof with this form or I can wait until I am asked for it. I don't have to send proof to enroll. However, if I am asked for my proof and I don't provide it, my premium may be increased because of a late-enrollment penalty. For more information about the late-enrollment penalty, I may visit [www.medicare.gov](http://www.medicare.gov) or 1-800-MEDICARE (1-800-633-4227); (hearing impaired users should call 1-877-486-2048), 24 hours a day, 7 days a week.
5. 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.
6. I understand that beginning on the date Erickson Advantage<sup>®</sup> Plan coverage begins, I must have services provided or arranged by my primary care physician except for emergency and urgently needed services and out-of-area renal dialysis. If I receive routine care that has not been arranged by my primary care team, I will access non-preferred benefits. Services authorized by Erickson Advantage<sup>®</sup> and other services contained in my Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **neither Medicare nor Erickson Advantage<sup>®</sup> will pay for the services.**
7. I understand that Medicare has special enrollment rules for the Erickson Advantage<sup>®</sup> Champion Plan. I understand that my Enrollment Form may be declined or I may be disenrolled for any of the following reasons:
  - I do not have a qualifying medical condition for enrollment in the Erickson Advantage<sup>®</sup> Champion Plan.
  - Erickson Advantage<sup>®</sup> is unable to confirm with my health care provider that I have a qualifying medical condition.
  - I apply for enrollment during a Special Enrollment Period determined by Medicare for individuals with a qualifying condition to enroll in Erickson Advantage<sup>®</sup>, but Erickson Advantage<sup>®</sup> cannot confirm that I have a qualifying condition.

**Fraud warning:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Enrollment Form or files a claim containing a false or a deceptive statement, has committed insurance fraud. Commission of insurance fraud may result in disenrollment or denial of benefits and may subject the individual to civil or criminal liability.

Enrollee's name \_\_\_\_\_  
 Proposed effective date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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**8. Please read this important information**

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 Enrollment Form means that I have read, understand and agree to the contents of this Enrollment Form, Statements of Understanding and the Additional Statement of Understanding (for the plan I have chosen) on this form.

**You must sign and date this Individual Enrollment Form in order for it to be processed.**

If signed by an authorized representative of the applicant, 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 Medicare.

Signature of applicant/member/authorized representative	Today's Date ____ / ____ / ____
---	------------------------------------

**If you are the authorized representative of the applicant, you must provide the following information and sign above.**

Name		Relationship to applicant	
Address		Telephone Number (      )	
City	State	ZIP Code	Alternate Phone Number (optional) (      )

**9. For sales representative/agency use only**

Selling Staff Member/Agent ID	Initial Receipt Date
Selling Staff Member/Agent Name	Proposed Effective Date
Agent Telephone Number	Did the agent assist in completing the application? <input type="checkbox"/> Yes <input type="checkbox"/> No
Agent Signature (required)	

**10. Election period**

AEP  
 ICEP  
 IEP (MA or MA-PD enrollees)  
 IEP (MA-PD enrollees eligible for 2nd IEP)  
 OEPI  
 SEP (SEP Reason Code \_\_\_\_\_ )

Enrollee's name \_\_\_\_\_  
 Proposed effective date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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Receipt

Important Enrollment Information

Application Date \_\_\_\_\_

Proposed Effective Date \_\_\_\_\_

Medicare ID \_\_\_\_\_

Plan Name \_\_\_\_\_

Health Plan/PBP Number \_\_\_\_\_

Insurance Agent ID \_\_\_\_\_

Insurance Agent Name \_\_\_\_\_

Insurance Agent Phone Number \_\_\_\_\_

I-Enroll Tracking Number (if applicable) \_\_\_\_\_

This copy verifies you met with an agent who sells Erickson Advantage,® administered by UnitedHealthcare,® products. Once UnitedHealthcare® receives the Enrollment Form, you will receive a copy of your original Enrollment Form in the mail within two weeks. This copy is for your records only. **Please do not resubmit.**

Please contact your insurance agent if you do not receive a copy of your original Enrollment Form in the mail within two weeks.



Talk to your local insurance agent for answers or to enroll.



If you do not have a local insurance agent, please call 1-800-989-1389, TTY 711, 8:30 a.m. – 5 p.m. local time, Monday – Friday.



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This information is available for free in other languages. Please contact our Erickson Advantage® Customer Service number at 1-800-989-1389, TTY/TDD: 711, 8:30 a.m. to 5 p.m. local time, Monday – Friday, for additional information.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro Servicio al Cliente de Erickson Advantage® al número 1-800-989-1389, TTY/TDD: 711, de 8:30 a.m. a 5 p.m. hora local, lunes – viernes, para obtener más información.