CoxHealth
MedicarePlus
Insured through Essence Healthcare

Please contact Essence Healthcare (HMO) if you need information in another language or format (Braille, Large Print, etc.)

TO ENROLL IN THE CoxHealth Medicare*Plus* PLAN, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Please check which plan you want to enroll in:

☐ CoxHealth Medicare*Plus* (HMO) - $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:
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:

- 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(as it appears on your Medicare card):

Medicare Number:

__ __ __ __ __ __ __ __ __ __ __

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

PAYING YOUR PLAN PREMIUM

If you enroll in a zero premium plan and it is 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 choose to pay by automatic deduction from your Social Security (SSA) or Railroad Retirement Board (RRB) benefit check, Electronic Funds Transfer (EFT) from your bank, [credit card, debit card or online check via a secure website, or check via mail. If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by 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 Essence Healthcare the Part D-IRMAA.

If you enroll in a plan with a premium (including any late enrollment penalty that you currently have or may owe) you can pay your monthly plan premium by mail, Electronic Funds Transfer (EFT), or credit card each month. You can

also choose to pay by automatic deduction from your Social Security (SSA) 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 Essence Healthcare 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. 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.

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

☐ Automatic deduction from your monthly Social Security (SSA) benefit check.

☐ Automatic deduction from your monthly 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.

Deduction will occur on the 9th day of the month. If the 9th day of the month falls on a non-business day, deduction will occur the following business day. If your EFT rejects two months in a row, your payment option will be changed to Direct Pay and you will begin receiving invoices

☐ Credit Card. Your monthly invoice will provide information regarding how to establish a secure on-line account to make credit card payments.

☐ Get a Monthly Bill and pay by Check or Credit Card.

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 CoxHealth Medicare*Plus*? ☐ 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 & 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 READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining CoxHealth Medicare*Plus* could affect your employer or union health benefits. You could lose your employer or union health coverage if you join CoxHealth Medicare*Plus*. 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 CHOOSE THE NAME OF A PRIMARY CARE PHYSICIAN

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

PLEASE READ AND SIGN BELOW

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

Essence Healthcare (HMO) 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.

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

Release of Information: By joining this Medicare health plan, I acknowledge that CoxHealth Medicare*Plus* will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that CoxHealth Medicare*Plus* 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 from CoxHealth Medicare*Plus* 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:

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 or Large Print

Please contact CoxHealth Medicare*Plus* at 1-866-509-5399 if you need information in another format or language than what is listed above. Our office hours are 8:00 AM – 8:00 PM 7 days a week. You may receive a messaging service on weekends and holidays from April 1 through September 30. TTY users should call 711.

FOR OFFICE USE ONLY

Name of Producer (if assisted in enrollment):

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

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

Special Election Periods: (Check all that apply)

☐ **SEP-S: SPAP**
- ☐ Loss of SNP
- ☐ Retro Entitlement
- ☐ Invol. Loss/Cred. Coverage
- ☐ Contract/Plan Non-Renewal
- ☐ Contract Violations
- ☐ Contract Term – Immediate
- ☐ Contract Term – MAO
- ☐ Contract Term – CMS
- ☐ CMS Sanction
- ☐ Not informed/Cred. Coverage
- ☐ Error/Fed Employee

☐ **SEP-V (Permanent Move)**

☐ **SEP-W (EGHP SEP)**

☐ **SEP-U: Dual Eligible**
- ☐ Medicaid Loss
- ☐ Non-Dual with LIS
- ☐ Non-Dual LIS loss/Redeeming
- ☐ Non-Dual LIS loss/Determining

☐ **Not Eligible**

Producer:	**Producer #:**	**Application Receipt Date**:

CoxHealth
MedicarePlus
Insured through Essence Healthcare

Please return completed application to:

Essence Healthcare
P.O. Box 12487
St. Louis, MO 63132

Please call 1-866-509-5399 for more information, including free language translation services, regarding your CoxHealth Medicare*Plus* plan. TTY users call the national relay service toll free at 711. Our telephone lines are open 7 days a week from 8:00 a.m. to 8:00 p.m. You may receive a messaging service on weekends and holidays from April 1 through September 30. Please leave a message and your call will be returned the next business day. Essence Healthcare is an HMO with a Medicare contract. Enrollment in Essence Healthcare depends on contract renewal. You must continue to pay your Medicare Part B premium.