OneCare (HMO SNP) Individual Enrollment Form
Please contact OneCare if you need information in another language or format (braille).

To Enroll in OneCare, Please Provide the Following Information:			
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):			
City:		State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address): Street Address: City: State: ZIP Code:			
Emergency contact: _____ **Phone Number**: _____ **Relationship to You:** _____			
Email Address:_____			

Please Provide Your Medicare Insurance Information

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

- Fill out this 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.

Name (as it appears on your Medicare card):
_____
Medicare Number: _____
Is Entitled To: Effective Date:
HOSPITAL (Part A) _____
MEDICAL (Part B) _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

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 anymore, **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 OneCare? ☐ 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 Medi-Cal program? ☐ Yes ☐ No
   If "yes," please provide your Medi-Cal number on your beneficiary identification card (BIC).
   BIC #: _____

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

Please choose a Primary Care Physician (PCP) and a Medical Group.

PCP Name: _____ PCP ID Number: _____ Medical Group Name: _____

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format:

___ Spanish ___ Vietnamese ___ braille, audio tape or large print

Please contact OneCare toll-free at **1-877-412-2734** if you need information in an accessible format or language other than what is listed above. TDD/TTY users should call **1-800-735-2929** toll-free, 24 hours a day, 7 days a week. Our office hours are Monday through Friday from 8:00 a.m. to 5:00 p.m.

Please Read This Important Information

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

OneCare is a Medicare Advantage HMO SNP plan and has a contract with the federal government. I will need to keep my Medicare Part A and B and Medi-Cal. I can only be in 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 OneCare of any Medicare Advantage coverage that I have or may get in the future.

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

Release Information:
By joining this Medicare Advantage HMO SNP plan, I acknowledge that OneCare will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that OneCare 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 State law 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 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: _____

Office Use Only:

Plan ID #:_____

Effective Date of Coverage: _____ IEP:_____ AEP:_____ SEP (type):___

Name of Plan Representative/agent/broker: _____

OneCare (HMO SNP) is a Medicare Advantage organization with a Medicare Contract and a contract with the California Medi-Cal (Medicaid) program. Enrollment in OneCare depends on contract renewal. The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan. Limitations, co-payments, and restrictions may apply. Benefits may change on January 1 of each year.

OneCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at 1-877-412-2734, 24 hours a day, 7 days a week. TDD/TTY users can call 1-800-735-2929.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-877-412-2734** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-412-2734** (TTY: **1-800-735-2929**).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電**1-877-412-2734** (TTY: **1-800-735-2929**).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-412-2734** (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-412-2734** (TTY: **1-800-735-2929**).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-412-2734** (TTY: **1-800-735-2929**)번으로 전화해 주십시오.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-877-412-2734** (TTY (հեռատիպ)՝ **1-800-735-2929**):

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

باشماره **1-877-412-2734** (TTY: **1-800-735-2929**) تماس بگیرید.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-412-2734** (телетайп: **1-800-735-2929**).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-877-412-2734** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:

ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم

1-877-412-2734 (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**).

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।

1-877-412-2734 (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।.

Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-877-412-2734** (TTY: **1-800-735-2929**).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-877-412-2734** (TTY: **1-800-735-2929**).

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-877-412-2734** (TTY: **1-800-735-2929**) पर कॉल करें।.

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-877-412-2734** (TTY: **1-800-735-2929**).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-877-412-2734 (TTY: 1-800-735-2929)**.