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: ( )
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:** _____			
E-mail Address:_____			

Please Provide Your Medicare 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.

SAMPLE ONLY

Name:_____

Medicare Claim Number Sex__

__ __ __- __ __ - __ __ __ __ __

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Please Answer the Following Questions:

1. 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: _____

2. 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):_____

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

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

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

Please Read This Important Information

If you are a member of a Medicare Advantage Plan (like a HMO or PPO), you may already have prescription drug coverage from you Medicare Advantage Plan that will meet your needs. By joining OneCare, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

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 understand that this Medicare Advantage HMO SNP coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A and B coverage. It is my responsibility to inform OneCare of any Medicare Advantage coverage that I have or may get in the future. I can only be in one Medicare Advantage plan at a time – if I am currently in a Medicare Advantage Prescription Drug Plan, my enrollment with OneCare will end that enrollment.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

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. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use OneCare network pharmacies. 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.

I understand that if I leave this plan and don't have or get other Medicare Advantage coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

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.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Release of 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 _____

Medicare Advantage HMO SNP Plan 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.

This information is available for free in other languages. Please call our Customer Service number at 1-877-412-2734, 24 hours, 7 days a week, for additional information. (TDD/TTY users should call 1-800-735-2929).

Esta información está disponible gratis en otros idiomas. Para más información, por favor llame al Departamento de Servicios para Miembros al 1-877-412-2734, las 24 horas al día, los 7 días de la semana. (Usuarios de la línea TDD/TTY pueden llamar al 1-800-735-2929).

Thông tin này cũng có sẵn miễn phí bằng những ngôn ngữ khác. Xin vui lòng liên lạc Văn Phòng Dịch Vụ của chúng tôi qua số điện thoại 1-877-412-2734, 24 giờ một ngày, 7 ngày một tuần, để biết thêm chi tiết.

(Thành viên sử dụng máy TDD/TTY có thể liên lạc qua số 1-800-735-2929).