MOLINA HEALTHCARE

Please contact Molina Medicare Options Plus HMO SNP if you need information in another language or format (Braille).

2015 Individual Enrollment Request Form
To Enroll in Molina Medicare Options Plus, Please Provide the Following Information

Please check which plan you want to enroll in

Molina Medicare Options Plus HMO SNP – A Medicare Advantage Prescription Drug Special Needs Plan

- ❑ CA H5810 001 Southern CA $0 per month
- ❑ CA H5810 007 Northern CA $0 per month
- ❑ FL H8130 001 $0 per month *
- ❑ MI H5926 001 $0 per month *
- ❑ NM H9082 007 $0 per month *
- ❑ OH H0490 004 $0 per month *
- ❑ TX H7678 001 $0 per month *
- ❑ UT H5628 001 $0 per month *
- ❑ WA H5823 006 $0 per month *
- ❑ WI H2879 001 $0 per month *

**Your monthly plan premium may be $0 to $39.70 based upon your level of Extra Help.*

Last Name | **First Name** | **MI**

Birth Date (M M / D D / Y Y Y Y)

Sex ❑Male ❑Female

❑ Mr. ❑ Mrs. ❑ Ms.

❑ Jr. ❑ Sr. ❑ Other _____

Home Phone Number | **Alternate Phone Number**

Permanent Residence Street Address (P.O. Box is not allowed) | **Apt/Unit/Space**

City | **State** | **ZIP Code** | **County**

Mailing Address (only if different from your Permanent Residence Address) ❑(same as permanent)
Address | City | State | ZIP Code

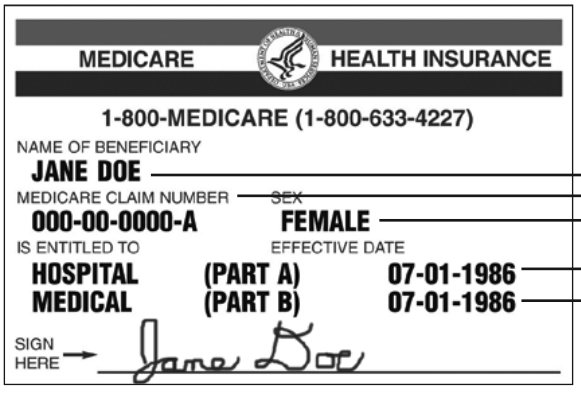
E-mail Address

Emergency Contact

Relationship to You | **Phone Number**

Please Provide Your Medicare Insurance Information

Please take out your red, white, and blue Medicare card to complete this section – **OR** – attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.



Name (exactly as it appears on Medicare card)

Medicare Claim Number / / Letter(s)

Sex ❑Male ❑Female

Part A (Hospital) Effective Date (M M / D D / Y Y Y Y)

Part B (Medical) Effective Date (M M / D D / Y Y Y Y)

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

Paying Your Plan Premium (If Applicable)

If you have a monthly plan premium or if we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you prefer to pay it.

You can pay by mail, "Electronic Funds Transfer (EFT)" each month, or we will provide you with 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 (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium, if your plan has a premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Molina Medicare Options Plus 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 in the form of a coupon book for the amount that Medicare doesn't cover.

If you don't select a payment option, you will receive a coupon book in the mail.

Please select a premium payment option

❑ Coupon Book

❑ Electronic Funds Transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following

Account Holder Name

Bank Routing Number Bank Account Number

Account type ❑ Checking ❑ Saving

❑ 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 coupon book 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. **Will you have any other prescription drug coverage such as private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs in addition to Molina Medicare Options 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

If available, please include effective date of 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 ID Number

5. Do you or your spouse work? ❑**Yes** ❑**No**

Please choose a Primary Care Provider (PCP) and enter the PCP's name, ID #, address, etc. below.
(Required – please refer to the plan website or Provider Directory for selection.)

PCP (last name, first)

Are you an existing patient? ❑**Yes** ❑**No**

PCP ID #

Clinic/Health Center or Medical Group/IPA

PCP Address

Please check one of the boxes below if you would prefer to be sent information in a language other than English or in another alternate format. ❑Spanish ❑Braille ❑Audio ❑Large Print

Please contact Molina Medicare Options Plus at (800) 665-3086 if you need information in another format or language other than what is listed above. Our office hours are 7 days a week, 8:00 a.m. to 8:00 p.m., local time. TTY users should call 711.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Molina Medicare Options Plus could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Molina Medicare Options 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 Read and Sign Below

By completing this enrollment application, I agree to the following

Molina Medicare Options Plus (the "Plan") 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 enrolled 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 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. I may leave this Plan or make changes only when an enrollment period is available (Example: Medicare's Annual Election Period, October 15 – December 7), or under certain special circumstances.

This Plan serves a specific service area. If I move out of the area that the Plan serves, I need to notify the Plan so I can disenroll and find a new plan in my new area. 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. Once I am a member of the Plan, I have the right to appeal Plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from the Plan when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.

I understand that beginning on the date the Plan's coverage begins; I must get all of my health care from in-network contracted providers and pharmacies, except for emergency or urgently needed services or out-of-area dialysis services. I understand that authorized services and other services contained in my Plan's Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MOLINA MEDICARE OPTIONS PLUS WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual he/she may be paid based on my enrollment in the Plan.

Release of Information By joining this Medicare Advantage plan, I acknowledge that Molina Medicare Options Plus will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that the Plan 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 Medicare.

Signature of Applicant or Authorized Representative*	**Today's Date**
X	**X** ☐☐ / ☐☐ / ☐☐☐☐ M M / D D / Y Y Y Y

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

Name

Relationship to Applicant

Address

Phone Number ☐☐☐ ☐☐☐ - ☐☐☐☐

Molina Medicare Options Plus is a Health Plan with a Medicare Contract and a contract with the state Medicaid program. Enrollment in Molina Medicare Options Plus depends on contract renewal. This plan is available to anyone who has both Medical Assistance from the State and Medicare. You must continue to pay your Medicare Part B premium. If you are a full dual member, your State may cover your Part B premium, based upon your level of Medicaid eligibility. This information is available in other formats, such as Braille, large print, and audio. This information is available for free in other languages. Please call our customer service number at (800) 665-3086, TTY/TDD 711, 7 days a week, 8 a.m. – 8 p.m., local time. Esta información está disponible gratuitamente en otros idiomas. Por favor, comuníquese a nuestro número de teléfono para servicio al cliente al (800) 665-3086, TTY/TDD 711, los 7 días de la semana, de 8:00 a.m. a 8:00 p.m., hora local.

Agent/Sales Rep/Office Use Only

Name of Rep/Agent (if assisted in enrollment)

Agent Writing # Proposed Effective Date ☐☐ / ☐☐ / ☐☐☐☐

Receipt Date ☐☐ / ☐☐ / ☐☐☐☐ P#

Election Period (Check One) ❑ICEP/IEP ❑AEP ❑SEP (Type) ❑Not Eligible

Member's preferred speaking language if other than English (if applicable)