Enrollment Form

Please contact Molina Healthcare if you need information in another language or format (Braille).

To Enroll in Molina Medicare Choice Care, Please Provide the Following Information

You will be enrolling in:

☐ **ID H5628-009 HMO $0 per month**

LAST Name:	FIRST Name:	Middle Initial:	☐ Mrs. ☐ Mr. ☐ Ms.

Birth Date: (MM/DD/YYYY)	Sex: ☐ M ☐ F	Home Phone Number: ( )	Alternate Phone Number: ( )

Permanent Residence Street Address (P.O. Box is not allowed):

City:	County:	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 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: (MM/DD/YYYY)
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

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

Paying Your Plan Premium

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 would prefer to pay it. You can pay by mail, "Electronic Funds Transfer (EFT)" each month. 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 the RRB. DO NOT pay Molina Healthcare the Part D-IRMAA.

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or "Electronic Funds Transfer (EFT)" each month. 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 Molina 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.

If you don't select a payment option, you will get a coupon book.

Please select a premium payment option:

☐ Get a 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 ☐ Savings

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(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.)

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 Molina Healthcare?

☐ 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 choose the name of a Primary Care Physician (PCP), clinic or health center:

PCP Name (LAST NAME, FIRST NAME): _____

***Are you an existing member: ☐ Yes ☐ No**

Provider NPI #: _____ Clinic/Medical Group/IPA: _____

PCP Address: _____

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

☐ Spanish ☐ Braille ☐ Audio ☐ Large Print

Please contact Molina Healthcare at (800) 665-3086 if you need information in an accessible format or language other than what is listed above. Our office hours are 7 days a week, 8 a.m. to 8 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 Healthcare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Molina Healthcare. 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 Healthcare 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.

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

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

Complete all the sections of the enrollment form and the attestation of eligibility for an Enrollment Period. Sign and date the form.

If applying by mail, send the signed copy to:
Molina Healthcare, Inc.
Attn: Enrollment Accounting
PO BOX 22800
Long Beach, CA 90801

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment):

Agent Writing # (NPN): _____

Agent Name (Printed): _____ Signature: _____

Agent Receipt Date: ___/___/___/_____ Agent Phone #: _____

Plan ID# _____ Effective Date of Coverage: _____

P#: _____

*Receipt Date of Enrollment request. This date will be used to determine the election period in which the request was made, which in turn will determine the effective date of coverage.

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