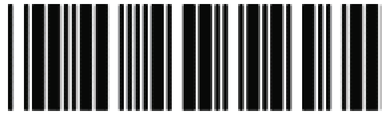
**HIP**®
an EmblemHealth company



# 2010

## PART D NEW YORK

**To Enroll in HIP Health Plan of New York, Please Provide the Following Information:**

☐ **HIP Part D New York Standard** ☐ **HIP Part D New York Enhanced**

| Last Name: | | First Name: | M.I. ☐ Mr. ☐ Mrs. ☐ Ms. |
|---|---|---|---|
| Birth Date: ____/____/_______ | Sex: ☐ M ☐ F | | Home Phone Number: ( ) ______-__________ |
| **Permanent Address (No. PO Boxes):** | | | |
| City: | | State: | ZIP Code: |
| **Mailing Address** (only if different from Home Address): | | | |
| City: | | State: | ZIP Code: |
| **Emergency Contact:** | | **Phone Number:** | **Relationship to you:** |
| **E-mail Address:** | | | |

**Please Provide Your Medicare Insurance Information**

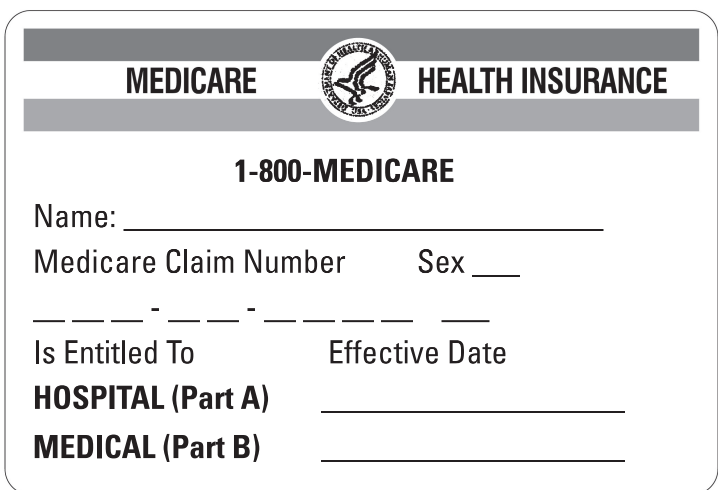
Please take out your Medicare card to complete this section.

- 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 or Part B to join a Medicare Advantage Plan.** ➔


MEDICARE HEALTH INSURANCE
1-800-MEDICARE
Name: ______________________________
Medicare Claim Number Sex ___
___ ___ ___ - ___ ___ - ___ ___ ___ ___ ___
Is Entitled To Effective Date
HOSPITAL (Part A) ____________________
MEDICAL (Part B) ____________________

## Please Read and Answer These Important Questions:

**1.** You can have the monthly premium for this Medicare plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month which you can pay by mail or by Electronic Funds Transfer (EFT). Generally you must stay with the option you choose for the rest of the year.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% of 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 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 Securty 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 may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if there is any, deducted from your monthly check.

**Would you like the premium for this plan deducted from your SSA monthly benefit check?** ☐ Yes ☐ No

**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 this plan? ☐ 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): ______________________________

**Please check one of the boxes below if you would prefer us to send you information in a language other than English.** ☐ Spanish ☐ Chinese

*Please contact HIP at **1-800-447-8255** if you need information in another format or language than what is listed above. TTY users should call **1-888-447-4833**. Our office hours are from 8 am and 8 pm Monday through Friday (TTY users from 8 am and 5 pm, Monday through Friday).*

**Marital Status:** ☐ Single ☐ Married ☐ Widow(er) ☐ Other ______________

**Power of Attorney, Conservator, Guardian: (please choose one if applicable)**

☐ Power of Attorney ☐ Conservator ☐ Guardian ☐ None

**Name:** **Phone#:** ( _____ ) ______ __________

## Please Read This Important Information

**If you are a member of a Medicare Advantage Plan** (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining HIP Part D New York, 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 HIP Part D New York could affect your employer or union health benefits.** You lose your employer or union coverage if you join HIP Part D New York. 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 on Reverse

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

HIP Part D New York is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or B coverage. It is my responsibility to inform HIP Part D New York of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare Prescription Drug Plan at a time. If I am currently in a Medicare prescription drug plan, my enrollment in HIP Part D New York 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 (Nov. 15 - Dec. 31), unless I qualify for certain special circumstances.

HIP Part D New York serves a specific service area. If I move out of the area that HIP Part D New York 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 HIP Part D New York network pharmacies. Once I am a member of HIP Part D New York, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from HIP Part D New York when I receive 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 prescription drug 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 HIP Health Plan of New York, he/she may be paid based on my enrollment in a HIP Medicare Plan.

Counseling services may be available in my state to provide advise 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 health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that HIP 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 HIP Health Plan of New York or by Medicare.

| **Your Signature:** | |
|---|---|
| **Proposed Effective Date:** | **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:** ____________________

## For Company Use Only

Staff Member/Agent/Broker Signature: ____________________

Plan ID: ____________________ Manager ID: ____________________

**Election Period:** ICEP/IEP: ____________ OEP: ____________ AEP: ____________ SEP (type): ____________

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