AgeWell NEW YORK HEALTH PLANS — Feel Well, Live Well with

2018 Individual Enrollment Request Form

If you have questions, please contact AgeWell New York at:
1-866-586-8044 or TTY 1-800-662-1220
Fax Enrollment form to 1-855-895-0784

Please contact AgeWell New York if you need information in another language or format (Braille).

PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN

Nassau, Queens, Kings (Brooklyn), Bronx, New York (Manhattan) and Westchester Counties

☐ **(H4922-005-01) LiveWell (HMO) $0** PER MONTH
☐ **Add Optional Dental** $16.00 per month

Suffolk County

☐ **(H4922-005-02) LiveWell Suffolk (HMO) $19.00** per month
☐ **Add Optional Dental** $16.00 per month

Nassau, Queens, Kings (Brooklyn), Bronx, Suffolk, New York (Manhattan) and Westchester Counties

☐ **(H4922-006) StayWell (HMO) $0 or up to $39.00** per month
☐ **(H4922-003) FeelWell (HMO SNP) $0** per month
☐ **(H4922-002) BeWell (HMO SNP) $0 or up to $39.00** per month
☐ **(H4922-004) CareWell (HMO SNP) $0 or up to $39.00** per month

TO ENROLL IN AGEWELL NEW YORK, PLEASE PROVIDE THE FOLLOWING INFORMATION

LAST Name:		FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ 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:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):

City:	State:	ZIP Code:
Emergency Contact:	**Phone Number:**	**Relationship to You:**

E-Mail Address:

Do you have an authorized representative? ☐ **No** ☐ **Yes:** ☐ **Power of Attorney** ☐ **Conservatorship** ☐ **Guardianship**

PLEASE PROVIDE YOUR MEDICARE INFORMATION

Please take out your 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.

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

insert image

Name as it appears on Medicare card:

____

Medicare Number:________________________

Is Entitled to:	Effective Date:
HOSPITAL (Part A)	____________
MEDICAL (Part B)	____________

PAYING YOUR PLAN PREMIUM

If you have a plan premium AND/OR 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 mailing a personal or certified check. 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 AgeWell New York 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 bill each month.

Please select a premium payment option:

Get a bill. (Note: If you are enrolled in your State Pharmaceutical Assistance Program (Elderly Pharmaceutical Assistance Program- EPIC) please select "Get a Bill" option to prevent double deduction of your premium.

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

I get monthly benefits from: ☐ Social Security or ☐ Railroad Retirement Board (RRB)

(The Social Security or 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. (Please check all that apply) Some individuals may have other drug coverage, including
☐ Other Private Insurance ☐ TRICARE ☐ Federal employee health benefits coverage ☐ VA benefits, or ☐ State pharmaceutical assistance programs (EPIC).

Will you have other prescription drug coverage in addition to **AgeWell New York?** ☐ 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: ______________________

Name of other coverage: ____________________ ID # for this coverage: ______________
Group # 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 facility:_______________ Address:_______________

City:_______________ State:__________ Zip:__________ Tel: (____)_______________

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

If yes, do you have coverage through you or your spouse's employer? ☐ Yes ☐ No

Name of other coverage: _______________ ID # for this coverage: _______________

Group # for this coverage: _______________

Please choose the name of a Primary Care Physician (PCP), in our network

PCP name:_______________ PCP address_______________

City:_______________ State:__________ Zip:__________ Tel: (____)_______________

New Physician for you ☐ Yes ☐ No

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

☐ Spanish ☐ Chinese ☐ Braille ☐ Audio tape ☐ Large print ☐ Other: _______________.

Please contact **AgeWell New York** at 1-866-586-8044 if you need information in another format or language than what is listed above. You can call us 7 days a week from 8:00 am to 8:00 pm Eastern time. TTY users should call 1-800-662-1220.

PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining AgeWell New York could affect your employer or union health benefits. You could lose your employer or union health coverage if you join AgeWell 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 any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

EMAIL PREFERENCES

Go Green, Go Paperless!

Please provide a valid email address below

Member's email: _______________

You can choose to opt out of receiving email from AgeWell New York at any time.

Agent/Broker: For the email address entry above, use only member's email address.

By giving my email address, I agree to receive email about my benefits, health programs and other plan services. I understand I can change my email preference by calling Member Services.

Get important plan documents by email. Check the box next to each item you wish to receive by email, instead of postal mail.

I want to receive my Welcome Kit by email. This includes my first year Evidence of Coverage, information on how to access my Provider/Pharmacy directory and List of Covered Drugs (Formulary) and other helpful information.

I want to receive my Annual Notice of Change kit by email. This includes my Annual Notice of Change, my new Evidence of Coverage, information on how to access my Provider/Pharmacy directory and List of Covered Drugs (Formulary) and other helpful information.

PLEASE READ AND SIGN BELOW

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

AgeWell New York 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.

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

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

Office/Agent/Broker Use Only

Name of Staff Member/Agent/Broker (if assisted in enrollment):____

Plan ID #: ______________________ Effective Date of Coverage: ______________________

ICEP/IEP: __________ AEP: __________ SEP (type): __________ Not Eligible: __________

Enrollment Department Agent/Broker Application Receive Date: ___________________________________

Agent/Broker NPN ID#: ___________________________________

Please print all information in black ink - keep the yellow copy for your records. Fax white copies to 1-855-895-0784. Mail all other documents or payments to: **AgeWell New York, 1991 Marcus Avenue, Suite M201, Lake Success, New York, 11042.**

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AgeWell New York, LLC is a Health Maintenance Organization (HMO) plan with a Medicare contract and a Coordination of Benefits Agreement with New York State Department of Health. Enrollment in AgeWell New York, LLC depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. This plan is available to anyone who has both Medical Assistance from the State and Medicare. This plan is available to anyone with Medicare who meets the Skilled Nursing Facility (SNF) level of care and resides in a nursing home.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Call 1-866-586-8044 (TTY: 1-800-662-1220).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1- 866-586-8044 (TTY: 1-800-662-1220).

AgeWell New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AgeWell New York does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. AgeWell New York provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact AgeWell New York Member Services at 1-866-586-8044.
If you believe that AgeWell New York has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

AgeWell New York
Civil Rights Coordination Unit
1991 Marcus Avenue Suite M201
Lake Success, New York 11042-2057
1-866-586-8044
TTY/TDD: 1-800-662-1220
Fax: 855-895-0778
Email: civilrightsunit@agewellnewyork.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordination Unit is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, TDD: 1-800-537-7697
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.