Office of Management and Enterprise Services
Employees Group Insurance Department
APPLICATION FOR MEDICARE ADVANTAGE PRESCRIPTION DRUG (MA-PD) PLAN
A separate application must be submitted for each Medicare beneficiary enrolling.

Member ID #_____ Phone # _____

Email Address_____ Alternate Phone # _____

Member Name _____
First M.I. Last

Member SSN _____ Member Date of Birth _____ Sex ☐ M ☐ F

Dependent Name _____
(if enrolling in Medicare) First M.I. Last

Dependent SSN _____ Dependent Date of Birth _____ Sex ☐ M ☐ F

Permanent Residence_____
(P.O. Box is not allowed) Street City State ZIP Code County

Mailing Address_____
(if different than above) Street City State ZIP Code County

If your dependent is the person enrolling in Medicare, complete the rest of the application using your dependent's information.

Provide Your Medicare Insurance Information
We Must Have This Information to Process Your Application

You must have Medicare Part A and Part B to join an MA-PD plan.

Please take out your Medicare card to complete this section.

- Fill in the blanks to the right 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 Railroad Retirement Board.

MEDICARE HEALTH INSURANCE

Name:_____

Medicare Claim Number Sex _____

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

Is Entitled To	Effective Date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

Please Answer the Following Questions

1. In which MA-PD plan do you want to enroll?

Aetna Medicare	☐
CommunityCare Senior MA-PD	☐
Generations by GlobalHealth	☐

2. 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, the MA-PD plan may need to contact you to obtain additional information.*

3. Some individuals may have other prescription drug coverage through private insurance, TRICARE, federal employee health benefits, VA benefits, workers' compensation, or state pharmaceutical assistance programs. Do you have other **prescription** drug coverage? ☐ Yes ☐ No

If yes, please list your other coverage and your identification (ID) number(s) for your coverage:
Name of other coverage: _____ ID #:_____ Group #:_____

Typically, you can enroll in an MA-PD plan *only* during the annual enrollment period *from* Oct. 15 *through* December 7 of each year. Please check the box below if you are enrolling during an annual enrollment period.

☐ I am enrolling during an annual enrollment period (Option Period).

There are exceptions that may allow you to enroll in an MA-PD plan outside of this period.

4. Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I recently moved outside the service area of my current plan, or I recently moved and this plan is a new option for me. I moved on (insert date) _____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.

☐ I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums.

☐ I get Extra Help paying for Medicare prescription drug coverage.

☐ I no longer qualify for Extra Help paying for my Medicare prescription drug coverage. I stopped receiving Extra Help on (insert date) _____.

☐ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home). I moved/will move into/out of the facility on (insert date) _____.

☐ I recently left a Program of All-Inclusive Care for the Elderly (PACE) program on (insert date) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date) _____.

☐ I am leaving employer or union coverage on (insert date) _____.

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

☐ None of these statements apply to me. Please contact the Office of Management and Enterprise Services (OMES) Employees Group Insurance Department (EGID) at 405-717-8780 or toll-free 800-752-9475 Monday through Friday, 7:30 a.m. to 4:30 p.m., Central Time to see if you're eligible to enroll. TDD users call 405-949-2281 or toll-free 866-447-0436.

Would you prefer that the MA-PD plan send you information in a language other than English or in another format?

☐ Yes ☐ No If you mark yes, please contact the MA-PD plan directly. See contact information below.

PRIMARY CARE SELECTION

As an MA-PD plan member, you must choose a primary care physician (PCP) who will coordinate your health care. Once you choose an MA-PD plan, you can obtain a list of the plan's network physicians by contacting your plan or going to one of the websites listed below.

Aetna
Member Services / Monday through Friday / 8:00 a.m. to 6:00 p.m.
P.O. Box 981106, El Paso, TX 79998-1106
Toll-free 1-888-267-2637
Website: **www.aetnamedicare.com/en/for-members/group-plans.html**

CommunityCare Senior Health Plan
Member Services / Monday through Sunday / 8:00 a.m. to 8:00 p.m., Central Time
P.O. Box 3327, Tulsa, OK 74101
Toll-free 1-800-642-8065
Relay Service for the Hearing Impaired toll-free 1-800-722-0353
Website: **www.ccok.com**

Generations State of Oklahoma Retiree Plan by GlobalHealth
Customer Care / Monday through Sunday / 8:00 a.m. to 8:00 p.m., Central Time
P.O. Box 1747, Oklahoma City, OK 73101-1747
Current Members: 1-405-280-5555 or toll-free 1-844-280-5555 or TTY 711
Prospective members: toll-free 1-844-322-8422 or TTY 711
Website: **www.globalhealth.com/medicare**

Physician's First Name: _____

Physician's Last Name: _____

Are you currently a patient of the physician: ☐ Yes ☐ No

Please Read This Important Information

By completing this enrollment application, I agree to the following:
The MA-PD plans offered through EGID are Medicare Advantage Prescription Drug plans and they have a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one MA-PD plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform EGID 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 if an enrollment period is available (example: annual enrollment period from Oct. 15 – Dec. 7), or under certain special circumstances.

The MA-PD plans offered through EGID serve a specific service area. If I move out of that service area, I need to notify EGID and the plan so I can disenroll and find a new plan in my new area. Once I am a member of an MA-PD plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the member handbook or Evidence of Coverage document from the MA-PD plan when I get it so I know which rules I must follow to get coverage through my MA-PD 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 my MA-PD plan coverage begins, I must get all of my health care from that plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by the MA-PD plan and other services contained in my MA-PD Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MY MA-PD PLAN WILL PAY FOR SERVICES.**

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

Member Signature: _____ Date: _____

Dependent Signature: _____ Date: _____
(Required only if dependent is enrolling in an MA-PD plan.)

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

Name: _____

Address: _____

Phone Number: _____

Relationship to Enrollee: _____

You must return this form to EGID at the address or fax number listed below.

For more information regarding this application, contact EGID:

Office of Management and Enterprise Services
Employees Group Insurance Department
P.O. Box 58010, Oklahoma City, OK 73157-8010
1-405-717-8780 or toll-free 1-800-752-9475 or TDD 1-405-949-2281 or toll-free TDD 1-866-447-0436
Fax 1-405-717-8939