

For **Generations Value**, please continue to Section 4 of this application.

For **Generations Classic**:

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), or credit card each month. You can also 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 GlobalHealth the Part D–IRMAA.**

For **Generations Select**:

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail, Electronic Funds Transfer (EFT), or credit card 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 Railroad Retirement Board. **DO NOT pay GlobalHealth the Part D–IRMAA.**

For **Generations Classic & Generations Select**:

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, 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 won't have a coverage gap or a late enrollment penalty. Many people qualify 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 only pays 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
- 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

Name	2008
Address	
City, State Zip	Date _____
Pay to the order of _____	\$ <input type="text"/>
	_____ Dollars
Memo _____	
<input type="checkbox"/> 1 2 3 4 5 6 7 8 9 <input type="checkbox"/>	<input type="checkbox"/> 1 2 3 4 5 6 7 8 9 <input type="checkbox"/> 2008
Routing Number	Account Number

- Credit Card. Please provide the following information:

Type of Card:

Name of Account Holder

as it appears on card:

Account Number:

Expiration Date: / (MM/YYYY)

- 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 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 ATTACH VOIDED CHECK HERE

SECTION 4

Please Read and Sign Below:

GlobalHealth is a plan that has a contract with the Federal government.

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

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 healthcare operations. I also acknowledge that GlobalHealth 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 people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date GlobalHealth coverage begins, I must get all of my healthcare from GlobalHealth, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by GlobalHealth and other services contained in my GlobalHealth Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR GLOBALHEALTH WILL PAY FOR THE SERVICES.**

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.

SECTION 4 (cont.)

Please Read and Sign Below:

Signature: _____

Today's Date:

____/____/____

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

Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____ - _____ - _____

Relationship to Enrollee: Child Friend Spouse Other _____

Office Use Only

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

Plan ID Number: _____ Effective Date of Coverage: ____/____/____

Agent Signature: _____

ICEP/IEP:

AEP:

SEP:

Not Eligible:

(Type): _____

Office Use Only, Plan ID Numbers

Generations Value: 1020160

Generations Classic: 1020161

Generations Select: 1020167

GlobalHealth is an HMO plan with a Medicare contract. Enrollment in GlobalHealth depends on contract renewal.