MEDICAL MUTUAL®

2017 Enrollment Application

Please contact Medical Mutual at (866) 406-8777 (TTY 711 for hearing impaired) if you need information in another format or language.

Return completed application by fax to (800) 542-2583 or by mail to:

Medical Mutual
P.O. Box 94563
Cleveland, OH 44101

Note: If you are working with an agent/broker, he or she may provide different submission instructions.

MedMutual Advantage HMO and PPO Plans

Region 1 Counties

Ashland, Brown, Butler, Carroll, Clark, Clermont, Columbiana, Cuyahoga, Delaware, Fairfield, Franklin, Fulton, Geauga, Greene, Hamilton, Hancock, Hocking, Holmes, Lake, Licking, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Miami, Montgomery, Morgan, Morrow, Perry, Pickaway, Portage, Seneca, Stark, Summit, Trumbull, Union, Warren, Wayne, Wood, Wyandot

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Z8176-MCA R8/16

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To enroll in a Medicare Advantage plan, please provide the following information:

1. Medicare Information (Please take out your Medicare card to complete this section)

Please fill in the blanks so they match your red, white and blue Medicare card or attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board. **You must have Medicare Part A and Part B to join a Medicare Advantage plan.**

Medicare Claim Number	Hospital (Part A) Effective Date	Medical (Part B) Effective Date
	/ /	/ /

2. Applicant Information

Last Name	First Name	MI	Title ☐ Mr. ☐ Ms. ☐ Mrs.
Birthdate (MM/DD/YYYY)	**Sex** ☐ Male ☐ Female	**Primary Phone Number** ( ) –	**Secondary Phone Number** ( ) –

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

City	State	ZIP Code	County

Mailing Address (Only if different from your Permanent Residence Address)

City	State	ZIP Code

Email Address

Please Note: By providing this email address, you are giving Medical Mutual permission to send you an email message (e.g., confirming we received your application and/or information about how to opt in to receive additional plan-related email communications).

3. Plan Selection Information (Region 1)

Please check the MedMutual Advantage plan you want to enroll in:

- ☐ **MedMutual Advantage Classic HMO** ($0 per month)
  - ☐ Add Optional Supplemental Benefits Package to this plan for an additional $25 per month
- ☐ **MedMutual Advantage Choice HMO** ($29 per month)
  - ☐ Add Optional Supplemental Benefits Package to this plan for an additional $25 per month
- ☐ **MedMutual Advantage Select PPO** ($39 per month)
  - ☐ Add Optional Supplemental Benefits Package to this plan for an additional $25 per month
- ☐ **MedMutual Advantage Preferred PPO** ($69 per month)
  - ☐ Add Optional Supplemental Benefits Package to this plan for an additional $25 per month
- ☐ **MedMutual Advantage Premium PPO** ($109 per month)

Please Note: The Optional Supplemental Benefits Package is not available to add to MedMutual Advantage Premium PPO, as this plan already includes extra vision and dental benefits.

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4. Primary Care Physician Information (Optional)

Physician Name	Physician Phone Number ( ) –	Physician's NPI Number	
Physician's Street Address			
City		State	ZIP Code

5. Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty 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 (IRMAA), 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 Medical Mutual 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 percent or more of your drug costs, including monthly prescription drug premiums, annual deductibles and coinsurance. 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 (800) 772-1213. TTY users should call (800) 325-0778. You can also apply for extra help online at 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.

Please select a premium payment option (If you don't select a payment option, you will get a bill each month):

☐ **Get a bill**

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

☐ **Electronic Funds Transfer (EFT) from your bank account each month**
Please enclose a voided check or provide the following information:

Account Type	Bank Routing Number	Bank Account Number
☐ Checking Account		
☐ Savings Account		

Account Holder's Name

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In-Network and Out-of-Network Considerations

Please Note: You pay less when you get health services from providers in your network.

- **With an HMO plan:** You must see an in-network provider for Medical Mutual to pay any amount on claims submitted on your behalf. If you go out of network, you will have to pay all charges due to the provider up to the full amount.
- **With a PPO plan:** You must see an in-network provider for Medical Mutual to pay the maximum amount on your claims. Claims for services from an out-of-network provider will be paid at a lower benefit level. You will be responsible for paying the additional amount. Out-of-network/non-contracted providers are under no obligation to treat Medical Mutual members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

6. Please read and answer these important questions (Please check all that apply below)

☐ Yes ☐ No	**1. Do you have or have you ever had End-Stage Renal Disease (ESRD)?** If yes, you will need to supply us with a note from your doctor or records to show you have had a successful kidney transplant and/or you don't need regular dialysis anymore. Please include this with your application or fax to (800) 542-2583 or mail to: P.O. Box 94563, Cleveland, OH 44101. Otherwise, we may need to contact you to obtain additional information.		
☐ 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 prescription drug coverage in addition to the MedMutual Advantage plan you selected?** If yes, please list your other coverage and your identification (ID) number(s) for this coverage:		
	Name of Coverage	ID Number	Group Number
		Rx Bin (Optional)	Rx PCN (Optional)
☐ Yes ☐ No	**3. Are you enrolled in your state Medicaid program?** If yes, please provide your Medicaid number:		
	Medicaid Number		
☐ Yes ☐ No	**4. Do you or your spouse work?**		

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7. Attestation of Eligibility (Please check all that apply)

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

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 this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

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

☐ I recently was released from incarceration. I was released 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 recently obtained lawful presence status in the United States. I got this status 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 drugs. 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 PACE program on (insert date) _____/_____/_____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare coverage). 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) _____/_____/_____.

☐ I am already eligible for Medicare because of a disability, and I recently turned 65.

If none of these statements apply to you or you're not sure, please contact Medical Mutual at (866) 406-8777 (TTY 711 for hearing impaired) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m. seven days a week from October 1 through February 14 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday and 9 a.m. to 1 p.m. Saturdays from February 15 through September 30 (except holidays).

STOP: PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining a MedMutual Advantage HMO or PPO plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join a MedMutual Advantage HMO or PPO plan. 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.

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8. Terms and Conditions (Please read and sign below)

By completing this enrollment application, I agree to the following:
MedMutual Advantage HMO and PPO plans are Medicare Advantage plans offered by Medical Mutual through 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 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 through December 7 of every year), or under certain special circumstances.

Each MedMutual Advantage plan serves a specific service area. If I move out of the area that my plan serves, I need to notify Medical Mutual so I can disenroll and find a new plan in my new area. Once I am a member of Medical Mutual, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Medical Mutual when I get it to know which rules I must follow to get coverage with this plan. I understand people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

For HMO plans, I understand I must get all my healthcare from network providers, except for emergency or urgently needed services or out-of-area dialysis services. For PPO plans, I understand using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Medical Mutual provides refunds for all covered services, even if I get services out of network. For HMO and PPO plans, to get in-network coverage for out-of-area dialysis services, I understand I must be temporarily outside the plan's service area and use a Medicare-certified dialysis facility. Services authorized by Medical Mutual and in my Evidence of Coverage will be covered. **Without authorization, neither Medicare nor Medical Mutual will pay for the services.**

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

Proxy
I appoint the Secretary of Medical Mutual of Ohio as my proxy to act for me at any annual or special meeting of the members of Medical Mutual of Ohio. The Secretary will act as fully and to the same extent that I could act if personally present at the meeting. This proxy will be in effect for 10 years from the date of my signature below or the effective date of my coverage, whichever date is later. This proxy may be taken back at any time by mailing a letter to the Secretary.

Email Address
I understand if I have included my email address in this application, I am authorizing Medical Mutual to send me an email confirming it received my application and/or information about how to opt in to receive additional email communications. All other communications, including whether or not my application was approved for coverage will be sent by mail to the permanent address or mailing address I provided in Section 2. Medical Mutual will not sell my email information and will only send me email communications that I agree to receive by email.

Release of Information
By joining this Medicare health plan, I acknowledge that Medical Mutual will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that Medical Mutual will release my information including my prescription drug event data to Medicare, which may release it for research and other purposes that follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand if I intentionally provide false information on this form, I will be disenrolled from the plan.

Medical Mutual will use and disclose my information as permitted by law and consistent with Medical Mutual's Notice of Privacy Practices (available at MedMutual.com or by calling (800) 982-3117 (TTY 711 for hearing impaired).

I understand 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 I have read and understand the contents of this application. My actual effective date will be based on my eligibility.

Signature	Today's Date	Preferred Effective Date

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9. Authorized Representative Information (If applicable)		
Please Note: If signed by an authorized individual (as described in Section 8), this signature certifies 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare. If you are the authorized representative, you must sign page 5 and provide the following information:		
Authorized Representative's Name		
Address		
City	**State**	**ZIP Code**
Relationship to Enrollee	**Home Phone Number** ( ) –	
Please Note: All mail will be sent to the permanent address or mailing address provided in Section 2 of this application.		

The following section should be completed only by the insurance agent/broker assisting with this application.

Agent/Broker Use Only (If applicable)	
☐ Yes ☐ No	**Was this an individual one-on-one (e.g., face-to-face, conference call) appointment? If yes, the Scope of Appointment form must be attached.**
☐ Yes ☐ No	**Did you review provider networks/affiliations with the applicant?**
☐ Yes ☐ No	**Did you explain to the applicant the differences between in-network and out-of-network coverage?**
Agent/Broker's Name (Please print)	
Date Application Received by Agent/Broker	**National Producer Number** (NPN)