PMC Medicare Choice
HMO

2011
Enrollment Form

Next Page >

Please contact PMC Medicare Choice (PMC) (HMO), if you need information in another language or format (Braille).

To enroll in PMC, please provide the following information:

Last Names: **First Name:** **Middle Initial:** ☐ **Mr.** ☐ **Mrs.** ☐ **Ms.**

Birth Date: MM - DD - YYYY **Sex:** ☐ **M** ☐ **F** **Home Phone Number:** ___ - ___ - ____ **Alternate Phone Number:** ___ - ___ - ____

Permanent Residence Address (Physical 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:** **Previous Medical Coverage:**

Please check which plan you want to enroll in:

Plan	PBP Number	Coverage	Monthly Premium
☐ **Elite Dorado** (HMO POS)	**015**	**Medical and Prescription Drug**	**$ 0**
☐ **Medicare en el Hogar Plus** (HMO SNP)	**035**	**Medical and Prescription Drug**	**$ 0**
☐ **Premier Preferred** (HMO SNP)	**048**	**Medical and Prescription Drug**	**$ 0**
☐ **Max** (HMO)	**050**	**Medical and Prescription Drug**	**$ 0**
☐ **Dorado** (HMO)	**025**	**Medical only**	**$ 0**

☐ **Selection of Platino Benefit**

Medicare Platino is an option of coverage provided by **PMC** with the Federal Government and the **Commonwealth of Puerto Rico** (Reforma). The Administration of Health Services had combined their benefits to offer the Medicare Platino Program for all the beneficiaries enrolled in Reforma with Medicare Parts A and B.

PMC Medicare Choice

Next Page >

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 the Social Security or the Railroad Retirement Board.

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

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name:

Last Names:

Medicare Claim Number - - Sex ☐ M ☐ F

Is entitled to: Effective Date

HOSPITAL (PART A) MM - DD - YYYY

MEDICAL (PART B) MM - DD - YYYY

Paying Your Plan Premium

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 or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

If you don't select a payment option, you will get a coupon book.

Please select a premium payment option:

☐ Get a coupon book

☐ 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 ☐ Savings

☐ Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please read and answer these important questions

1. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No
   If you answered "yes" to this question and you don't need regular dialysis any more, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant.

PMC Medicare Choice

Next Page >

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 **PMC**? ☐ 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: _____

Phone number of Institution: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Address (number & street): _____

4. Are you enrolled in Puerto Rico's Government Health Plan (Reforma)? ☐ Yes ☐ No

If yes, please provide your Medicaid number: ☐☐☐ - ☐☐ - ☐☐☐☐ - ☐☐☐
Please provide a copy of your Notification of action taken in regards to request and/or reevaluation of medical assistance program (MA10) form, or provide your Social Security Number for us to confirm your Medicaid coverage: ☐☐☐ - ☐☐ - ☐☐☐☐

5. Do you or your spouse work? ☐ Yes ☐ No

Please include the information of the Primary Care Physician (PCP) that you selected:

Last names: **First name:**

Phone number of your PCP: ☐☐☐ - ☐☐☐ - ☐☐☐☐

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 ☐ Braille ☐ Large Print ☐ Audio format ☐ Other (specify) _____

Please contact PMC at 787-625-2126 (Metro Area), 1-866-516-7700 (toll free) if you need information in another format or language other than what is listed above. Our office hours are Monday through Sunday, from 7:30 a.m. to 8:00 p.m. TTY users should call 1-866-516-7701.

PMC Medicare Choice

Next Page >

Please Read This Important Information

If you currently have health coverage from an employer or union, joining PMC could affect your employer or union health benefits. You could lose your employer or union health coverage if you join PMC. 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.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:
PMC 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. If I am enrolling in Dorado Plan (a Medicare Advantage plan without prescription drug coverage): I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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.

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

Release of Information: By joining this Medicare health plan, I acknowledge that PMC will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that PMC 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 Commonwealth of Puerto Rico 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 the Commonwealth of Puerto Rico law to complete this enrollment and 2) documentation of this authority is available upon request by PMC or by Medicare.

PMC Medicare Choice

Next Page >

I certify that I have received the following documents from the Sales Representative/Agent/Independent Producer of PMC:

- ☐ Copy of Enrollment Form
- ☐ Provisional Proof of Enrollment
- ☐ Evidence of Coverage (EOC)
- ☐ Provider and Pharmacy Directory
- ☐ Drug Formulary (if applicable)
- ☐ Summary of Benefits (SB)
- ☐ Privacy Notice

Name of Individual who assisted you with the enrollment:

Today's date: MM - DD - YYYY

Signature of Beneficiary:

Witness:

If you are a witness, you must sign below and provide the following information:

Name **Last Names**

Permanent Residence Address

City **State** **ZIP code** **Phone Number**

Relationship to Enrollee

Witness signature

Authorized representative (Legal Guardian):

If you are the authorized representative (Legal Guardian), you must sign below and provide the following information:

Name **Last Names**

Permanent Residence Address

City **State** **ZIP code** **Phone Number**

Relationship to Enrollee

Authorized Representative (Legal Guardian) signature

PMC Medicare Choice

Next Page >

Official Use Only:

☐ **ICEP/IEP** ☐ **AEP** ☐ **SEP**

	SEP Code	Special election period affirmations (SEP)
○	MOV	During the next month I will move, or during the last two months I have moved out of the coverage area that my actual plan serves. Date of move _____
○	MDE	I have Medicare and Medicaid, or my state helps me with the payment of Medicare premiums.
○	LEC	I no longer meet the requirements for the coverage of my former employer or I dropped the coverage of an employer. Date of loss _____
○	OTH	I have special needs that allow for an exception to my subscription (PMC, will evaluate your case and will communicate with you)

Official Use Only:

Name of Sales Representative/Agent/Independent Producer (if assisted in enrollment):

Plan ID #:

Date received by Sales Representative/Agent/Independent Producer: MM - DD - YYYY

Effective Date of Coverage: MM - DD - YYYY

Sales Location:

☐ Seminar ☐ In-home ☐ Mail ☐ In-office ☐ Fax ☐ Other

☐ Telephone UCID: ___ - ___ - ____

Where did you find information about PMC?

☐ **Newspaper** ☐ **Doctor's office** ☐ **Billboard** ☐ **Mail**
☐ **Magazine** ☐ **PMC Employee** ☐ **Brochure** ☐ **Internet**
☐ **Radio** ☐ **Friend or family Referral** ☐ **TV** ☐ **Previous Client**
☐ **PMC Office** ☐ **Fax** ☐ **Other** _____

Sales Representative Name/Agent/Independent Producer

_____

Sales Representative/Agent/Independent Producer Signature

Employee Number/Agent/Independent Producer _____

Appointment Confirmation Number _____

PMC Medicare Choice

Email: _____

Submit