



Preferred Gold/GoldAnywhere Enrollment Application & Part D Application INDIVIDUAL

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

Preferred Gold and GoldAnywhere are Medicare Advantage plans and are contracted with the Federal government. I will need to keep my 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. I also understand that if I enroll in a stand-alone Prescription Drug Plan (PDP), I will automatically be disenrolled from Preferred Gold or GoldAnywhere and transferred to the Original Medicare Plan (fee-for-service program).

It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I do not 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: November 15 – December 31 of every year), or under certain special circumstances.

MVP Health Plan, Inc. serves a specific service area. If I move out of the area that MVP 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 MVP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage (contract) from MVP when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date **Preferred Gold** coverage begins, I must get all of my health care from MVP, with the exception of emergency or urgently needed services or out-of-area dialysis services; OR

I understand that beginning on the date **GoldAnywhere** coverage begins, using services in-network can cost less than using services out-of-network, with the exception of emergency or urgently needed services or out-of-area dialysis services. If medically necessary, GoldAnywhere provides reimbursement for all covered benefits, even if received out of network. Services authorized by MVP and other services contained in my MVP Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MVP WILL PAY FOR THE SERVICES.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with MVP, he/she may be compensated based on my enrollment in MVP. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

By joining this plan, I attest that I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage or Medicare drug plan.

STOP

PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining Preferred Gold or GoldAnywhere could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Preferred Gold or GoldAnywhere may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their Web site, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Section 3: Medicare Card 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 Administration or Railroad Retirement Board.

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

Medicare Health Insurance

Name _____

Medicare Claim # -

Is Entitled To: Hospital (Part A) ____ / ____ / ____

Medical (Part B) ____ / ____ / ____

Section 4: Primary Care Physician (PCP) - not required for GoldAnywhere

Primary Care Physician (*full name required*) _____

Address _____

Existing patient? Yes No

Section 5: Please read and answer the following questions

1. Do you have End Stage Renal Disease (ESRD)? Yes No
If you answered yes to this question and you no longer need regular dialysis or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant.
2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or EPIC.
Will you have other prescription drug coverage in addition to MVP? Yes No
If yes, name of other coverage _____ ID # _____ Group # _____

Your answer to the following questions will not keep you from enrolling in this plan.

3. Are you a resident in a long-term care facility, such as a nursing home? Yes No
If yes, name of institution _____ Your date of admission _____
Address of institution (*number and street*) _____
_____ Phone number _____
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
6. Do you have existing Part D Prescription Drug Coverage? Yes No
If yes, what was the effective date of your existing coverage?
 The day I became eligible for Medicare
 January 1, 2006
 Other (*enter date*) _____
7. Since you became eligible for Medicare, have you had any prescription drug coverage or any insurance that included drugs other than Part D? Yes No

Section 6: Signature and Authorization

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 health care operations. I also acknowledge that MVP 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 behalf of the individual under the laws of the State where the individual resides) 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 by MVP or by Medicare.

PLEASE SIGN BELOW

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 _____

**Questions?
Call Gold Sales:
(888) 280-6205
TTY: (800) 252-2452**

For Plan Use Only

Enter in: <input type="checkbox"/> Amisys <input type="checkbox"/> Facets	If current member, please include member ID number: <input type="text" value="A"/> OR <input type="text" value="800"/>			
Previous ID # _____	Group Name _____	Group # _____		
Effective Date _____	Input Date _____	Initials _____		
<input type="checkbox"/> ICEP/IEP	<input type="checkbox"/> OEP	<input type="checkbox"/> AEP	<input type="checkbox"/> SEP (type): _____	Not eligible: _____
Date coverage should begin: _____ / _____ / _____				