SeniorCare (Cost)
SCOTT & WHITE HEALTH PLAN
Texas Friendly

SeniorCare Enrollment Form

Please contact [SWHP] if you need information in another language or format (Braille). Por favor póngase en contacto con SWHP si usted necesita la información en otra lengua o formato (Braille).

1 To enroll in SeniorCare (Cost), Please Provide the Following Information:

Please check which medical plan you want to enroll in: ☐ **Select** ☐ **Preferred** ☐ **Preferred Plus**

Please check which optional prescription plan you want to enroll in: ☐ **Value** ☐ **Basic** ☐ **Enhanced** ☐ **No Rx**

Please indicate your requested enrollment effective date: ______________________________

LAST Name: FIRST Name: Middle Initial: ☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date:
(_ _ /_ _ /_ _ _ _)
(M M / D D / Y Y Y Y)

Sex:
☐ M
☐ F

Home Phone Number:
(   )

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

City: State: ZIP Code:

Mailing Address (only if different from your Permanent Residence Address:)
Street Address: City: State: ZIP Code:

Emergency contact: ____
Phone Number: ________________________________ **Relationship to You:** ____________________

E-mail Address (optional):

2 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 Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B to join any of the SWHP plans listed above.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: ______________________________________

Medicare Claim Number **Sex** __________

_ _ _ - _ _ - _ _ _ _ _

Is Entitled To **Effective Date**

HOSPITAL (Part A) ________________

MEDICAL (Part B) ________________

3 Your Plan Premium Payment Option:

You can pay your monthly plan premium by mail using coupons, "Electronic Funds Transfer (EFT)", or online each month using "e-Pay". You can also choose to pay your premium by automatic deduction from your Social Security Check each month.

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 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 1-800-772-1213. TTY users should call 1-800-325-0778. Your 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 pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

If you don't select a payment option, you will receive coupons in the mail.

Please select a premium payment option:

☐ Receive coupons.

☐ Electronic funds transfer (EFT) from you bank account each month. Please enclose a VOIDED check or provide the following:

Account holder: ___________________________________

Bank routing number: ____________________________ Bank account number:___________________

Account type: ☐ Checking ☐ Savings

☐ E-Pay (online by going to our website by the first of each month at www.swhp.org (Credit Card payment available online)

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

4 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 do not need regular dialysis any more, 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. Do you or your spouse work? ☐ Yes ☐ No

   Do you have health coverage through your or your spouse's current or former employer? ☐ Yes ☐ No

   If "yes", please provide the following information:

   Employer Name: _________________________________ Employer Address: ________________________

   Policy Holder Name: ______________________________ Policy Number:____________________________

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: ______________________________
Address & Phone Number of Institution (number and street): ______________________________

4. Are you enrolled in your State Medicaid Program? ☐ Yes ☐ No

If "yes", please provide your Medicaid number: ______________________________

5. Some individuals may have other drug coverage, including other private insurance such as through an employer or spouse's employer, TRICARE, Federal Employee health benefits coverage, VA benefits or State Pharmaceutical assistance Programs.

Do you or will you have other prescription drug coverage in addition to SeniorCare (Cost) Rx? ☐ 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
______________________	______________________	______________________

Please choose the name of a Primary Care Physician (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 ☐ E-mail

Please contact SWHP at 1-800-782-5068 if you need information in another format or language than what is listed above. Our office hours are Monday-Friday, 8am to 5pm. TTY users should call 1-800-735-2989

Please Read This Important Information

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

5 Please Read and Sign Below:

By completing this enrollment application, I agree to the following:
SWHP is a Medicare plan with an optional supplemental Part D benefit and has a contract with the Federal government. I understand that I am not required to choose the optional supplemental Part D benefit. I will need to keep my Medicare Parts A and B. I can be in only one Medicare health plan or Part D drug plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or Medicare Part D prescription drug plan. It is my responsibility to inform SWHP of any prescription drug coverage that I have or may get in the future. I understand that if I don't have or get other 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 in a plan that includes Part D, I may leave the 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.

SWHP serves a specific service area. If I move out of the area that SWHP serves, I need to notify the plan so I can disenroll and find a new plan in my new area. If I enroll in a Part D plan, I understand that I must use network pharmacies except in an emergency when I cannot reasonably use SWHP network pharmacies.

Once I am a member of SWHP, I have the right to appeal plan decisions about payment or services if I disagree.

I will read the Evidence of Coverage document from SWHP when I get it to know which rules I must follow in order to get coverage. I agree to abide by the terms and conditions set forth in the Evidence of Coverage. 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. Services authorized by SWHP and other services contained in my SWHP Evidence of Coverage document will be covered.

Release of Information: By joining this Medicare health plan, I acknowledge that the SWHP will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that SWHP 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 statues 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 State law 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 by SWHP or by Medicare.

Your Signature:	**Today's date:**

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

Name: ____

Address: ____

Phone Number: (_____) ______ - __________

Relationship to Enrollee: ______________________________

Office Use Only:

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

Division #: ___________________________________ Area #: ______________________

Effective Date of Coverage: ____

IEP: _________ AEP: _________ SEP (type): ___________ Not Eligible: ___________