SeniorCare (Cost)
SCOTT&WHITE HEALTH PLAN
Texas Friendly

CHANGE FORM

① Please provide your information:

ID Number:	Medicare Claim Number (from your Medicare card):

Last Name / First Name / Middle Initial:	Date of Birth:

Home Phone Number: ( )	Email address (optional):

Mailing Address:	(City)	(State)	(Zip Code)

② Please make a plan selection:

Please check which medical plan you want to change to:	☐ Select ☐ Preferred ☐ Preferred Plus
Please check which optional SeniorCare (Cost) Medicare Part D prescription drug plan you want to add or change to:	☐ Value ☐ Basic ☐ Enhanced ☐ No Rx

③ Please read and sign on the next page:

By completing this "Change" form, I agree to the following:

SeniorCare (Cost) is a Medicare health plan and I will need to keep my Medicare Part B. I can only be in one Medicare health plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I know I may disenroll from this plan at any time by sending a written request to SeniorCare (Cost) or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

I understand that beginning on the date SeniorCare (Cost) coverage starts, in order for SeniorCare (Cost) to fully cover my medical services (except for emergency or urgently-need services), all of my health care must be provided or arranged by SeniorCare (Cost). If I obtain services not provided or arranged by the plan, I will be responsible for all Medicare deductibles and coinsurance, as well as any additional charges as prescribed by the Medicare program. I may also be liable for charges not covered by Medicare.

Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico. Services authorized by SeniorCare (Cost) and other services contained in my SeniorCare (Cost) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered.

This information is available in a different format, including Spanish. Please call Customer Services at 1-866-334-3141, Sunday – Saturday, 8 am to 8 pm (TTY users call 1-800-735-2989) if you need plan information in another format or language.

Esta información está disponible en un formato diferente, incluso el español. Por favor llame Servicios de Cliente en 1-866-334-3141, el domingo – el sábado, a las 8h00 hasta las 20h00 (usuarios de TTY llaman 1-800-735-2989) si usted tiene que planear la información en otro formato o lengua.

"A Health Plan with a Medicare Contract"

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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 SeniorCare (Cost) will release my information, including my prescription drug event data, to Medicare who may release it for research and other purposed which follow all application 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 Change form. If signed by an authorized individual (as described above), this signature certified that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon requires by SeniorCare (Cost) or by Medicare.

4 Please sign and date:

Your Signature:	Today's Date:

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

Name: ____

Address: ____

Phone Number: ____

Relationship to Enrollee: ____

MAIL FORMS TO:
Scott & White Health Plan
Attention SeniorCare
1206 West Campus Drive
Temple, TX 76502

FAX FORMS TO: Attention SeniorCare
1-254-298-3567

EMAIL FORMS TO: swhpseniors@swmail.sw.org

Office Use Only:

Division #: ______________________

Effective Date of Coverage: ______________ ☐ IEP ☐ AEP ☐ SEP (type): ____________

Plan Representative #: ________________ Area #: ______