Alignment Health Plan®

Employer/Retiree Group Enrollment Application

To enroll in a Medicare Advantage plan, you must have Medicare Part A and Part B and provide the following information:

To Enroll in Alignment Health Retiree Options, please provide the following information:

Employer or Union Name:		Group #:	
Plan Type: ☐ HMO ☐ PPO		☐ Enhanced Dental Option (only offered with H4961-801-002, 003, 004)	
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: (_____) _____- _____	Cell Phone Number: (_____) _____- _____
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	County:	State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address): Street Address:		City: State:	ZIP Code:
E-mail Address:			

Please Provide Your Medicare Insurance Information:

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number:

_____

Is Entitled to: _____ Effective Date: _____

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

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

Please read and answer these important questions

1. Are you the retiree? ☐ Yes ☐ No

If yes, retirement date (month/date/year): _____

If no, name of retiree: _____

2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No

If yes, name of spouse: _____

Name(s) of dependent(s): _____

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

4. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Alignment? ☐ Yes ☐ No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: ID # for Coverage:

_____ _____

5. 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): _____

_____

Please Choose a Primary Care Physician (PCP), clinic or health center:

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format:

☐ Spanish, Chinese, Vietnamese

Select one if you want us to send you information in an accessible format.

☐ Standard/Regular Font ☐ Braille ☐ Large Print ☐ Audio ☐ Data CD

Please contact Alignment Health Plan at 1-866-634-2247 (TTY 711) if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., 7 days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. If no selection is made, Standard/Regular font will be sent.

The following materials will be sent to you via email unless you prefer to receive a printed copy.

☐ Please check to receive printed copies of:

☐ Part C Explanation of Benefits (EOB); ☐ Part D Explanation of Benefits (EOB); ☐ Annual Notification of Change (ANOC).

Please Read and Sign Below

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

Alignment Health Plan 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 only be in 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. It is my responsibility to inform you of any prescription drug coverage that 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 if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

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

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 Alignment Health Plan 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 State 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 from Medicare.

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: _____

What Happens Next?

Send your completed and signed form to: **RetireeFirst Enrollment Department, 1000 Midlantic Drive, Suite 100 Mount Laurel, NJ 08054.** Once they process your request to join, they'll contact you.

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment):_____

Plan ID #:_____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Alignment Health Plan is an HMO, HMO POS, HMO C-SNP, HMO D-SNP and PPO plan with a Medicare contract and a contract with the California, Nevada, North Carolina and Texas Medicaid programs. Enrollment in Alignment Health Plan depends on contract renewal. Alignment Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.