



INSTRUCTIONS FOR JOINING GEMCARE HEALTH PLAN (GHP)

STEP ONE: Enrollment Eligibility

You are eligible to enroll in GEMCare Medicare Plus if:

- You are entitled to Medicare Part A (hospital insurance) and enrolled in Part B (medical insurance).
- You reside in Kern County, California
- You **do not** have end-stage renal disease (ESRD) or kidney failure requiring an ongoing dialysis program; or,
- In the event that you have **had** ESRD requiring dialysis, you have **had** a successful kidney transplant within the last 36 months and **no longer require** an ongoing dialysis program (documentation from your physician is required).

Normal enrollment occurs typically in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, **as long as you do not change your prescription drug coverage** (meaning, since you have prescription drug coverage with GHP, you must join another plan that has drug coverage as good as Medicare's or you can join original Medicare and a stand alone drug coverage plan). There are also situations that may allow you to enroll in a Medicare Advantage plan outside of these periods; some of these exceptions are stated in the 1st section of the enrollment form in the check box area.

If you currently have health coverage from an employer or union, joining GEMCare Health Plan could affect your employer or union health benefits. If you have health coverage from an employer or union, joining GEMCare Health Plan may change how your current coverage works. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

STEP TWO: Read Materials Carefully

Review the enclosed materials to understand the GEMCare Medicare Plus plan. If you have any questions, please contact GEMCare Medicare Plus at (661) 716-8800 or toll free at (877) 697-2464. TDD/TTY (888) 833-9312.

STEP THREE: Complete the Enrollment Form

Complete the GEMCare Health Plan Medicare Advantage Enrollment Form.

You will be asked to fill in the information about your Medicare benefits exactly as they appear on your Medicare card:

MEDICARE HEALTH INSURANCE	
SAMPLE ONLY	
Name: _____	
Medicare Claim Number _____	Sex _____
_____ - _____ - _____	
Is Entitled To	Effective Date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

(Continued on reverse side)

- **Select your physician group and doctor.** Be sure to fill in the names and numbers as they appear in the GEMCare Medicare Plus Physician Directory.
- **Read the questions and fill in the answers.**
- **Read the Important Information**
- **Sign and date the front side of the form, at the bottom.** Please make sure all sections have been filled out completely. **Mail your completed form in the envelope provided.** Your effective date of coverage depends on when you return this form to us. Keep the pink copy of the form as your temporary ID card.

If you have not yet received your Medicare card, you can attach a copy of your Letter of Verification from the Social Security Administration or Railroad Retirement Board.

GEMCare Health Plan will be in touch with you soon.

We will send you a letter confirming your enrollment and effective date. You will also receive a packet of information containing your ID card and other information about GEMCare Health Plan.

If you have any questions, please call us at **(661) 716-8800** or toll free **(877) 697-2464**. **TDD/TTY at (888) 833-9312.** We are open 8:00 am to 8:00 pm seven days a week.

Thank you for choosing GEMCare Medicare Plus. We are looking forward to taking care of you.



GEMCare Health Plan Medicare Advantage Enrollment Form

To Enroll in GEMCare Health Plan, Please Provide the Following Information:

Standard Medicare Advantage \$_____ per month *[Note: at time of enrollment the Late Enrollment Penalty (LEP) may not be known; if a LEP is confirmed by CMS, the cost per month may change.]*

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- | | |
|---|---|
| <input type="checkbox"/> I am new to Medicare. | <input type="checkbox"/> I'm in an annual (November 15 – December 31 st) or open enrollment (January 1 – March 31 st) period. |
| <input type="checkbox"/> I recently moved and this plan is a new option for me. | <input type="checkbox"/> I recently moved outside of the service area for my current plan. |
| <input type="checkbox"/> I receive extra help paying for Medicare prescription drug coverage. | <input type="checkbox"/> I have both Medicare and Medicaid or my state helps pay for my Medicare Premiums. |
| <input type="checkbox"/> I live in or recently moved out of a Long Term Care Facility (for example, a nursing home or long term care facility). | <input type="checkbox"/> I am no longer eligible for extra help paying for my Medicare prescription drugs. |
| <input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). | <input type="checkbox"/> I recently left a PACE program. |
| <input type="checkbox"/> I belong to a pharmacy assistance program provided by my state. | <input type="checkbox"/> I am leaving employer or union coverage. |
| | <input type="checkbox"/> I recently returned to the United States after living permanently outside of the U.S. |
| | <input type="checkbox"/> None of these statements applies to me.* |

**Please contact GEMCARE Health Plan at 661-716-8800 / 877-697-2464 (TTY users should call 888-833-9312) to see if you are eligible to enroll. We are 8:00 am to 8:00 pm seven days a week.*

LAST Name	FIRST Name	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date: ____/____/_____ <small>(MM / DD / YYYY)</small>	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #: <small>(providing this information is optional)</small> _____ - _____ - _____	Home Phone Number: (____) - ____ - ____
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Permanent Residence Street Address: _____

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

City:	State:	ZIP Code:
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Emergency contact:	Phone Number:	Relationship to You
	(____) - ____ - ____	_____

E-mail Address (if applicable): _____@_____._____

Please Provide Your Medicare Insurance Information

Your Medicare # (from red, white & blue Medicare card) _____

Entitlement: Part A Hospital date _____ Part B Medicare date _____

Paying Your Plan Premium-

Plan Premium Options: If we determine that you owe a late enrollment penalty, we will need to know how you would prefer to pay it. You can pay by mail each month, quarterly or yearly. You can also choose to pay your premium by automatic deduction from your Social Security Check each month.

If you do 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 or deduct it from your Social Security check.

If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

Receive a bill Monthly Quarterly Yearly

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 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. 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 GEMCare Health Plan? 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: _____ Address: _____

City, State, Zip: _____ Phone #: (_____) _____ - _____

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. Please choose the name of a Primary Care Physician (PCP), clinic or health center:

Primary Care Physician (PCP): _____ Provider ID (optional): _____

Provider Location (optional): _____ Primary Medical group: _____

7. Please check the box below if you would prefer us to send you information in a language other than English or in another format. To request the alternate format you can contact us at:

877-697-2464 / 661-716-8800 or TDD/TTY 888-833-9312. Spanish Large Print

8. Previous Health Plan (list who you are currently with): Original Medicare Just became eligible

Plan Name: _____ Does the plan cover prescription drugs? Yes No

Do you have a different prescription drug plan? Yes No If yes, who: _____

9. Would you like to designate and authorize another individual(s) to be able to ask about your personal health information? By doing so, you are allowing us to disclose the following types of information: billing or claims status, enrollment, authorizations, diagnoses, etc. *For example, if you have a spouse that you want to be able to call and ask about an authorization for you, they will be allowed to do this if you list their name below.*

Name _____ Relationship: _____ Date of Birth _____

Name _____ Relationship: _____ Date of Birth _____

Note: you can always change, add, update or remove this authorization in writing to GEMCare Health Plan at any time.

Please Read and Sign Below:

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

GEMCare 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 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. 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 15th of every year), or under certain special circumstances.

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

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.

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 GEMCare 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 statues and regulations. I acknowledge that GEMCare Health Plan may require access to my medical records and information in order to facilitate appropriate medical care. 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 GEMCare Health Plan or by Medicare.

Your 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
	(____) - ____ - _____	

OFFICE USE ONLY:

Name of Staff Member/Agent/Broker (if assisted in enrollment)	Date of Receipt by Agent/Broker/Staff Member	Plan ID #:	Effective Date of Coverage
	____/____/____ (MM / DD / YYYY)		____/____/____ (MM / DD / YYYY)

ICEP/IEP OEP AEP SEP (type): _____

Notes: