



**Joining GEMCare Medicare Plus**  
*Please read the following instructions for enrolling in GEMCare Medicare Plus.*

**Step One**

**Who is eligible?**

**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)/kidney failure or if you have ESRD but have had a transplant within the last 36 months that restored kidney function and you no longer require a regular course of dialysis to maintain life (documentation from your physician is required).

Typically, you may enroll 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. However, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

**Step Two**

**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 GEMCare Health Plan Medicare Advantage Enrollment Form.**

- **Fill in the information about your Medicare benefits exactly as they appear on your Medicare 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.

- **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” on the back.**
- **If you are applying for the GEMCare Medicare Plus Dual Eligible Plan, please provide a copy of your Medicaid card or entitlement letter.**
- **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.

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

**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.** Our hours of operation are Sunday through Saturday, 8am to 8pm Pacific.

**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
- Dual Eligible Special Needs \$ \_\_\_\_\_ per month (Must have both Medicare/Medicaid)

Please read the following statements and check the box to the left of the statement(s) and we will contact you for additional information:

- I am new to Medicare
- I recently moved outside of the service area for my current plan.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I was recently approved for extra help paying for Medicare prescription drug coverage.
- I just moved "into" a Long Term Care Facility (for example, a nursing home or long term care hospital)
- I recently "left" a PACE program.
- I recently involuntarily lost my creditable drug coverage (that is, coverage that is at least as good as Medicare's).
- I am either losing coverage I had from an employer or leaving employer coverage.

**If none of the statements applies to you or if you are not sure, please contact us to see if you are eligible to enroll.**

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>(M M/D D/Y Y Y Y)</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: <small>(only if different from your Permanent Residence Address):</small>	City:	State:	ZIP Code:
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Emergency contact:	Phone Number: (____) - ____ - _____	Relationship to You
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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 \_\_\_\_\_

### Your Plan Premium Option

**Do you want to pay your premium directly to your plan (this can include an automatic monthly deduction from your bank account)?**  Yes  No

**If you check no, we will contact you about having your premiums automatically deducted from your social security check. Please see the back of this form for more information.**

### 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: \_\_\_\_\_ 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. Since you became eligible for Medicare, have you had any prescription drug coverage or any insurance that included drugs?  Yes  No  
*If you answer no, your premium may be increased because of a late enrollment penalty. If you answer yes, we may ask you for proof that your previous prescription drug coverage was at least as good as Medicare's standard prescription drug coverage (creditable prescription drug coverage). You can send copies of your proof with this form or you can wait until we ask for it. You don't have to send your proof to enroll. However, if we ask for your proof and you don't provide it, your premium may be increased because of a late enrollment penalty. For more information about the late enrollment penalty, visit [www.medicare.gov](http://www.medicare.gov) or call 1-800-MEDICARE.*

Please choose the name of a Primary Care Physician (PCP), clinic or health center:  
Primary Care Physician (PCP): \_\_\_\_\_ Provider ID: \_\_\_\_\_  
Primary Medical Group: \_\_\_\_\_ Medical Group ID: \_\_\_\_\_

Please check the box below if you would prefer us to send you information in a language other than English:  Spanish

### -Please Read and Sign Below:

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 content on **both sides** 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 provide the following information:

Name & Address _____	Phone Number: _____	Relationship to Enrollee _____
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<b>Office Use Only:</b>	Name of Staff Member <small>(if assisted in enrollment)</small>	Plan ID #:	Effective Date of Coverage <small>(M M/D D /Y Y Y Y)</small>	<input type="checkbox"/> ICEP/IEP <input type="checkbox"/> OEP <input type="checkbox"/> AEP <input type="checkbox"/> SEP(type): _____
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## Important Information

**Plan Premium Options:** You can pay your Medicare drug plan directly for your monthly premium, or have the monthly premium automatically deducted from your Social Security check. If you choose to pay directly, you can pay by mail or Electronic Funds Transfer (EFT). Generally you must stay with the option you choose for the rest of the year.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want to pay your remaining premium, if there is any, directly to your plan.

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

GEMCare Health Plan is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage 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. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to GEMCare Health Plan or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

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 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. Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico. 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.**

**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.

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 prescription drugs or prescription drug coverage, or to pay for, in whole or in part, my enrollment in a Medicare drug 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. 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.