



**INSTRUCTIONS FOR JOINING GEMCARE MEDICARE PLUS HMO**

**STEP ONE: Enrollment Eligibility**

**You are eligible to enroll in GEMCare Medicare Plus HMO 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,
- If you have **had** ESRD and needed dialysis, but you **had** a successful kidney transplant within the last 36 months and **no longer require** dialysis (documentation from your physician is required).

**Typically, you may enroll in a Medicare Advantage Prescription Drug (MAPD) plan only during the Annual Enrollment Period (AEP) from October 15 through December 7 each year.** There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.


**STEP TWO: Read Materials Carefully**

Review the enclosed materials to understand the GEMCare Medicare Plus HMO plan. If you have any questions, please contact GEMCare Health Plan at (877) 697-2464 or (661) 716-8800. TTY users should call (888) 833-9312

**STEP THREE: Complete the Enrollment Form**

**Complete the GEMCare Medicare Plus 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:

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

- **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 are filled out completely. **Mail your completed form in the envelope provided.** The 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.

GHP 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 Medicare Plus HMO.

If you have any questions, please call us at (877) 697-2464 or (661) 716-8800. TTY users should call (888) 833-9312. Our hours are: 8:00am–8:00pm Monday through Friday (except holidays) from February 15 to October 14, and 8:00am–8:00pm seven days a week during the annual election period beginning on October 15, to February 14.

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



## GEMCare Medicare Plus HMO Medicare Advantage Prescription Drug Enrollment Form

Please contact GEMCare Medicare Plus HMO if you need information in another language or format (Large Print)

### To Enroll in GEMCare Medicare Plus HMO, Please Provide the Following Information:

GEMCare Medicare Plus HMO \$\_\_\_\_\_ 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 indicating, to the best of your understanding, 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 annual election period ( <b>October 15 - December 7 each year</b> ).   |
| <input type="checkbox"/> I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on:<br>____/____/_____<br><small>(MM /DD /YYYY)</small> | <input type="checkbox"/> I am moving into, live in, or recently moved out of a Long Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on: ____/____/_____<br><small>(MM /DD /YYYY)</small> |
| <input type="checkbox"/> I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.  | <input type="checkbox"/> I get extra help paying for Medicare prescription drug coverage   |
| <input type="checkbox"/> I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on: ____/____/_____<br><small>(MM /DD /YYYY)</small>                          | <input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on: ____/____/_____<br><small>(MM /DD /YYYY)</small>   |
| <input type="checkbox"/> I recently left a PACE program on: ____/____/_____<br><small>(MM /DD /YYYY)</small>  | <input type="checkbox"/> I am leaving employer or union coverage on: ____/____/_____<br><small>(MM /DD /YYYY)</small>  |
| <input type="checkbox"/> I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on: ____/____/_____<br><small>(MM /DD /YYYY)</small>                          | <input type="checkbox"/> I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on: ____/____/_____<br><small>(MM /DD /YYYY)</small>                           |
| <input type="checkbox"/> My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.   | <input type="checkbox"/> I belong to a pharmacy assistance program provided by my state.   |

If none of these statements applies to you or you're not sure, please contact GEMCare Health Plan at (877) 697-2464 or (661) 716-8800. TTY users should call (888) 833-9312 to see if you are eligible to enroll. Our hours are: 8:00am-8:00pm Monday through Friday (except holidays) from February 15 to October 14, 2011 and 8:00am-8:00pm seven days a week October 15 to February 14.

LAST Name	FIRST Name	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date: ____/____/_____ <small>(MM /DD /YYYY)</small>	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: (____) - ____ - ____	Alternative Phone Number: <input type="checkbox"/> Cell <input type="checkbox"/> Other _____ (____) - ____ - ____
Permanent Residence Street Address:			
City:		State:	ZIP Code:
<b>Mailing Address</b> (only if different from your Permanent Residence Address): <input type="checkbox"/> Same as Permanent Street Address:			
City:		State:	ZIP Code:
<b>Emergency contact:</b>	Phone Number:	Relationship to You	
	(____) - ____ - ____	_____	
E-mail Address (if applicable): _____@_____._____			

### Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section. Fill in the information as it appears on your card; or you can attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name: \_\_\_\_\_

Medicare Claim Number \_\_\_\_\_

Effective Dates: Part A Hospital \_\_\_\_\_ Part B Medicare \_\_\_\_\_



holidays) from February 15<sup>th</sup> to October 14<sup>th</sup> and 8:00am–8:00pm seven days a week October 15<sup>th</sup> to February 14<sup>th</sup>.



**Please Read This Important Information:**

**If you currently have health coverage from an employer or union, joining GEMCare Medicare Plus could affect your employer or union health benefits.** 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.

**Please Read and Sign Below:**

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

GEMCare Medicare Plus is a Medicare Advantage Prescription Drug 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, October 15 - December 7 each year), or under certain special circumstances.

GEMCare Medicare Plus serves a specific service area. If I move out of the area that GEMCare Medicare Plus 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 Medicare Plus 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 Medicare Plus when I get it to know which rules I must follow to get coverage with this Medicare Advantage Prescription Drug 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 GEMCare Medicare Plus coverage begins; I must get all of my health care from GEMCare Medicare Plus except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by GEMCare and other services contained in my GEMCare Medicare Plus *Evidence of Coverage document* (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR GEMCARE MEDICARE PLUS 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 GEMCare Medicare Plus he/she may be paid based on my enrollment in GEMCare Medicare Plus.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.

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

<b>Your Signature:</b>	<b>Today's Date:</b>
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If you are the authorized representative, you must sign above and provide the following information:

<b>Name &amp; Address</b>	<b>Phone Number:</b>	<b>Relationship to Enrollee</b>
	(____) - ____ - _____	

**OFFICE USE ONLY:**

<b>Name of Staff Member/Agent/Broker</b> (if assisted in enrollment)	<b>Date of Receipt by Agent/Broker/Staff Member</b>	<b>Plan ID #:</b>	<b>Effective Date of Coverage</b>
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	____/____/____ (MM / DD / YYYY)		____/____/____ (MM / DD / YYYY)
<input type="checkbox"/> ICEP/IEP <input type="checkbox"/> AEP <input type="checkbox"/> SEP (type): _____ Notes: Agent of Record:			