

**To Enroll in InFocus Health, Offered by Care Wisconsin Health Plan, Please Provide the Following Information:**

Last Name:	First Name:	Middle Initial:	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss
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Birth Date: (__/__/____) (MM / DD / YYYY)	Social Security Number: (providing this information is optional)	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):


Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

**E-mail Address:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Relationship to You:** \_\_\_\_\_

**Please Provide Your Medicare Insurance Information**

<p>Please take out your Medicare card to complete this section.</p> <ul style="list-style-type: none"> <li>• Please fill in these blanks so they match your red, white and blue Medicare card</li> <li>- OR -</li> <li>• Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.</li> </ul> <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>	 <p>SAMPLE ONLY</p> <p>Name: _____</p> <p>Medicare Claim Number _____ Sex _____</p> <p>_____ - _____ - _____</p> <p>Is Entitled To _____ Effective Date _____</p> <p><b>HOSPITAL (Part A):</b> _____</p> <p><b>MEDICAL (Part B):</b> _____</p>
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**Your Plan Premium Option**

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 by 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 the remaining premium, if there is any, directly to your plan.

**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 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 Care Wisconsin 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: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address (Street, City, State, ZIP Code): \_\_\_\_\_

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):**



**Please Read This Important Information**

**If you currently have health coverage from an employer or union, joining Care Wisconsin Health Plan could affect your employer or union health benefits.** If you have health coverage from an employer or union, joining Care Wisconsin Health Plan may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their Web site, 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.

**Please Read and Sign Below:**

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

Care Wisconsin 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 Care Wisconsin Health Plan or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Care Wisconsin Health Plan serves a specific service area. If I move out of the area that Care Wisconsin 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 Care Wisconsin 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 Care Wisconsin 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 Care Wisconsin Health Plan coverage begins, I must get all of my health care from Care Wisconsin 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 Care Wisconsin Health Plan and other services contained in my Care Wisconsin Health Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR CARE WISCONSIN HEALTH PLAN WILL PAY FOR THE SERVICES.**

**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.

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 Care Wisconsin Health Plan or by Medicare.

**Your Signature:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

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

**Name :** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Relationship to Enrollee:** \_\_\_\_\_

**Office Use Only:**

Name of Staff Member (if assisted in enrollment): \_\_\_\_\_ Plan ID #: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_ ICEP/IEP: \_\_\_\_\_ OEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP (type): \_\_\_\_\_