SHARP HEALTH PLAN
make life better.

Sharp Advantage℠

2015 Medicare EGWP Enrollment Form

Membership with MEA is not required to be eligible for this plan.

Please contact Sharp Health Plan if you need information in another language or format.

To Enroll in Sharp Advantage, Please Provide the Following Information:

Employer or Union Name: **MEA Medicare Retirees**	Group #: 25220001

Please check which plan you want to enroll in:

__✓__ **Sharp Advantage**

Plan: $166.00 per month

(81004)

This plan is for Medicare enrolled retirees only. If you are not eligible for Medicare, please contact MEA for the Non-Medicare Enrollment Form at 1-888-217-9175 or visit www.SDMEA.org to download the enrollment form.

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: ( )	Alternate 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:

Email Address:

Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

- OR -

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

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

SAMPLE ONLY

Name: _____

Medicare Claim Number Sex _____

_____

Is Entitled To: Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Mail to: **Sharp Health Plan**
Medicare Department
8520 Tech Way, Suite 200
San Diego, CA 92123

Please read and answer these important questions
1. Are you the retiree? ☐ Yes ☐ No If "Yes", list retirement date (month/date/year): If "No", list name of retiree:
2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No If "Yes", list name of spouse: Name(s) of dependent(s):
3. Do you or your spouse work? ☐ Yes ☐ No
4. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.
5. 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 Sharp Advantage? ☐ 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: _____ _____
6. 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 and Phone Number of Institution (number & street):
Please Choose a Primary Care Physician (PCP): **First Name:** **Last Name:** **City:** **State:** **Zip:**
Please check one of the choices below if you would prefer that we send you information in a language other than English, or in another format: _____ Spanish _____ Large Print Please contact Sharp Advantage at 1-855-820-2112 if you need information in another format or language than what is listed above (TTY users should call 711). Our office hours are from 8:00 a.m. to 6:00 p.m. Pacific Standard Time, Monday to Friday.

Please Read and Sign Below

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

Sharp Advantage 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), or under certain special circumstances.

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

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 Sharp Advantage 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:

Attestation of Eligibility for an Enrollment Period (City of San Diego)

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from June 1st through June 30th of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

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.

- ☑ I am a former employee or spouse/domestic partner/dependent of a former employee of the City of San Diego enrolling during open enrollment (June 1-June 30, 2015).
- ☐ I am new to Medicare.
- ☐ 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 (insert date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____.
- ☐ 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 (insert date) _____.
- ☐ I recently left a PACE program on (insert date) _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ☐ I am leaving employer or union coverage on (insert date) _____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ 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 (insert date) _____.

If none of these statements applies to you or you're not sure, please contact Sharp Advantage at 1-855-820-2112 to see if you are eligible to enroll (TTY users should call 711). We are open 8:00 a.m. to 6:00 p.m., Pacific Standard Time, Monday to Friday.

Office Use Only:
Plan ID #: 802 Effective Date of Coverage:_____

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