Enrollment Request Form

Please contact Stanford Health Care Advantage if you need information in another language or format (Braille).

Filling out and returning the enrollment request form is your first step to becoming a Stanford Health Care Advantage (HMO) member. If you and your spouse are both applying, you'll each need to fill out a separate form. For help completing the enrollment form, call our Member Services Contact Center at 1-855-996-8422 (TTY: 711), 8 am to 8 pm Pacific time, seven days a week (except for Thanksgiving and Christmas) from October 1 through March 31, Monday to Friday (except holidays) from April 1 through September 30.

How to fill out this form

1. Answer all questions and print your answers using black or blue ink.
2. Sign the form on page 6 and date it. **Make sure you've read all the pages before you sign.**
3. Mail the original, signed form to:
   P.O. Box 72530, Oakland, CA 94612
   Or fax form to: **1-510-588-5506**

Next Steps

- We will review your form to make sure it's complete. Then we will let you know by mail that we received it.
- We'll let Medicare know you've applied for Stanford Health Care Advantage.
- Within 10 calendar days after Medicare confirms you're eligible, we'll let you know when your coverage starts. Then we'll send you an ID card and welcome packet for new members.

Stanford Health Care Advantage is an HMO plan with a Medicare contract. Enrollment in Stanford Health Care Advantage depends on contract renewal.

Stanford
HEALTH CARE ADVANTAGE

Enrollment Request Form

Please contact Stanford Health Care Advantage if you need information in another language or format (Braille).

To Enroll in Stanford Health Care Advantage, Please Provide the Following Information:	
Please check which plan you want to enroll in: **(Check ONLY one)**	**Stanford Health Care Advantage (HMO)** ☐ Platinum ☐ Gold
Employer or Union Name:	Group #:
Are you a current or former member of any Stanford Health Care health plan?	Member ID:
LAST Name: FIRST Name: Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date:	Sex:	Home Phone Number:	Alternate Phone Number:
____/ ____/ _____ (MM/DD/YYYY)	☐ M ☐ F	( )	( )

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:

Emergency Contact: ____

Phone Number: ____________________ **Relationship to You:** ___________________________

E-mail Address: ____

Enrollment Request Form

Please contact Stanford Health Care Advantage if you need information in another language or format (Braille).

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card. - OR - • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card): ______________________ Medicare Number: ______________________ Is Entitled To: Effective Date: HOSPITAL (Part A) ____________ MEDICAL (Part B) ____________ You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Please read and answer these important questions:

1. 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.

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 Stanford Health Care Advantage (HMO)? ☐ 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 Number of Institution (number and street):

   ____

4. Do you or your spouse work? ☐ Yes ☐ No

Stanford HEALTH CARE ADVANTAGE

Enrollment Request Form

Please contact Stanford Health Care Advantage if you need information in another language or format (Braille).

5. If your employer provides retiree coverage, are you the retiree? ☐ Yes ☐ No

   If "yes", retirement date: ______________________

   If "no", name of retiree: ______________________ Retirement date: ____________________

6. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No

   If "yes", name of spouse: ____

   Name of dependent(s): ____

7. Requested Effective date: __________________________

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

Are you a current patient? ☐ Yes ☐ No

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

☐ Spanish ☐ Chinese ☐ Large Print

Please contact Stanford Health Care Advantage (HMO) at 1-855-996-8422 if you need information in an accessible format or language other than what is listed above. Our office hours are 8 am to 8 pm Pacific time, seven days a week (except for Thanksgiving and Christmas) from October 1 through March 31, Monday to Friday (except holidays) from April 1 through September 30. TTY users should call 711.

Please complete the information below:

If you currently have Stanford Health Care coverage through more than one employer or union/trust fund, you must choose ONE employer or union/trust fund from which to receive your Medicare Advantage coverage. Complete the information for that employer or union/trust fund below.

Employer Group/Union/Trust Fund Name: ____

Employer Group/Union/Trust Fund ID#: __________________________ Subgroup: _____________

Requested Effective date: __________________________

Stanford HEALTH CARE ADVANTAGE

Enrollment Request Form

Please contact Stanford Health Care Advantage if you need information in another language or format (Braille).

Please Read and Sign Below

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

Stanford Health Care Advantage (HMO) is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Part B, however some employer groups require both Parts A and B. I can be in only 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. I understand that if I don't have a Medicare prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. I may leave this plan at any time by sending a request to Stanford Health Care Advantage (HMO) or by calling 1-855-996-8422 (TTY: 711), 8 am to 8 pm Pacific time, seven days a week (except for Thanksgiving and Christmas) from October 1 through March 31, Monday to Friday (except holidays) from April 1 through September 30. However, before I request disenrollment, I will check with my group or union/trust fund to determine if I am able to continue my group membership.

I understand that if I currently have Stanford Health Care Advantage (HMO) through more than one employer or union/trust fund, I must choose one of these coverage options for my Medicare Advantage plan because I can be enrolled in only one Medicare Advantage plan at a time. My other employer or union/trust fund may allow me to enroll in one of their non-Medicare plans as well. I will contact the benefit administrators at each of my employers or union/trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or union/trust fund's plan to select from my Medicare Advantage plan.

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

Enrollment Request Form

Please contact Stanford Health Care Advantage if you need information in another language or format (Braille).

Release of Information: By joining this Medicare health plan, I acknowledge that Stanford Health Care Advantage (HMO) will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Stanford Health Care Advantage (HMO) 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: ______________________

Sales Agent/Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): ______________________

Plan ID #: ______________________ **Agent ID #:** ______________________

Effective Date of Coverage: ______________________ **Date Application Rec'd**: ______________________

ICEP/IEP: ______ AEP: ______ SEP (type): ______ Not Eligible: ______