SECTION SIX: Authorization and acknowledgement **Please read and sign on page three**

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

THealthPartners® Wisconsin Freedom plan (Cost) is a Medicare Cost plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B, or B only. I can only be in one Medicare health 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. I know I may disenroll from this plan at any time by sending a written request to HealthPartners or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

HealthPartners® Wisconsin Freedom plan (Cost) serves a specific service area. (See the Summary of Benefits for more details.) If I move out of the area that the Freedom 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 the Freedom plan, I have the right to appeal plan decisions about payment and services if I disagree. I will read the plan's Evidence of Coverage (EOC) to know which rules I must follow to get coverage with this Medicare Cost plan.

I understand that beginning on the date HealthPartners® Wisconsin Freedom plan (Cost) coverage starts, in order for the plan to fully cover my medical services (except for emergency or urgently-needed services), all of my healthcare must be provided or arranged by HealthPartners. If I obtain services not provided or arranged by the plan, I will be responsible for all Medicare deductibles and coinsurance, as well as any additional charges as prescribed by the Medicare program. I may also be liable for charges not covered by Medicare.

Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico. Services authorized by HealthPartners and other services contained in my HealthPartners® Wisconsin Freedom plan (Cost) Evidence of Coverage document (also know as a member contract) will be covered.

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with HealthPartners, he/she may be paid based on my enrollment in HealthPartners.

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.

I confirm that I am not getting any financial support from my or my spouse's current or former employer group or union to buy medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage or Medicare Prescription Drug Plan.

Contact HealthPartners Medicare Sales

By Phone

For questions about your medical plan options, call Medicare Sales at 952-883-5601 or 1-800-247-7015, Monday through Friday between 8 a.m. and 6 p.m. For questions about your prescription drug plan options, we're available seven days a week, 8 a.m. to 8 p.m. TTY users should call 952-883-6060 or 1-800-443-0156.

By Email

Email questions to **medicaresales@healthpartners.com**.

On the Web

Find more information or print off additional copies of this application at **healthpartners.com/medicare**.

Return applications in the enclosed postage-paid envelope to:

Riverview Membership Accounting, MS21103R
P.O. Box 9463
Minneapolis, MN 55440

Or fax them to 952-853-8746.

HealthPartners is a health plan with a Medicare contract.
This policy will be jointly issued by HealthPartners Inc. and HealthPartners Insurance Company.

8170 33rd Avenue South
PO BOX 1309
Minneapolis, MN 55440-1309

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FREEDOM WISCONSIN ENROLLMENT FORM

440265 (10/09)
H2462_WI EF_076 7/21/09

HealthPartners®

MedicareRx
Prescription Drug Coverage

Individual HealthPartners® Wisconsin Freedom Plan (Cost) Enrollment Form

This is the enrollment application for your HealthPartners® Wisconsin Freedom plan (Cost) medical and prescription drug options. Follow the steps outlined and review the important notes below before filling out your form

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Step 1: Determine if you're enrolling in medical coverage and/or prescription drug coverage. It's important to understand if you are eligible to enroll in prescription drug coverage prior to filling out this form. If you're unsure, please call Medicare Sales at the numbers on the back of this form.

Step 2: Select your choice of the two medical plans. If you choose Medical Plan I, you are not eligible for prescription drug coverage.

- **Wisconsin Freedom Plan I**
- **Wisconsin Freedom Plan II**

Step 3: If you have chosen Plan II, you can select the prescription drug plan coverage. You do not have to enroll in prescription drug coverage if you do not want to. If you select prescription drug coverage outside of a Medicare-approved enrollment period, the prescription drug portion of your application may be rejected. For more information, please see the back of this form.

Step 4: Fill out the remainder of the questions, including signing and dating the form. Forms that are not signed or dated will be returned. You should retain the color copy of this form for your records and mail the white copy back to HealthPartners in the enclosed self-addressed envelope. Each individual must complete a separate enrollment form.

Important Information

- You must be enrolled in the Federal Medicare Program for Part A and Part B, or Part B only, to join this plan. If you only have Medicare Part B, you will only be covered for Medicare Part B services. You must be enrolled or enrolling in Medical Plan II to enroll in prescription drug coverage.
- You must live in this plan's service area. This does not apply if you are a commercial HealthPartners member. However, if you move to a different address outside the service area after joining this plan, you will be disenrolled. For more information, see the enclosed Summary of Benefits.
- If you have End Stage Renal Disease (ESRD), which is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive, you cannot join this plan. For more information, see the enclosed Summary of Benefits.
- You must enroll in Medicare Part D prescription drug coverage during an approved enrollment period.
- Beneficiaries interested in assistance for prescription drug costs should contact Medicare Sales at the numbers on the back of this form or contact Medicare at 1-800-MEDICARE, 24 hours a day, seven days a week. TTY 1-877-486-2048.
- You will be asked to select a billing option in section three. Generally you must remain with that option for the full plan year. If you switch between direct bill and Social Security premium withhold at any point, it could take up to three months for the change to take effect and you will continue to be held responsible for those payments.
- This document is available in alternative formats and languages. Please contact Medicare Sales at the numbers on the back of this form for more information.

440265 10/09

HealthPartners® Wisconsin Freedom Individual Plan (Cost) Enrollment Form

SECTION ONE: Personal information

Last Name	First Name	M.I.	Sex ❑ M ❑ F
Birth Date (mm/dd/yyyy)	Home Phone (with area code)	Work Phone (with area code)	
Permanent Residence Address			Apt Number
City	State	Zip	County
In care of mailing address (if different from permanent home address)			Apt Number
City	State	Zip	County
In care of name	Email address (optional):		

Broker Name __________

Agency # ______________

HealthPartners Use Only

Effective Date

____

MR # ________________

Ctrct # _______________

____

SECTION TWO: Plan selection

Choose **ONE** medical plan option:

❑ **Plan I** - $59 per month *This plan is not eligible for drug coverage below.

❑ **Plan II** - $222 per month

If you selected Medical Plan II, please indicate whether you would like to enroll in the prescription drug plan:

❑ **Yes**, I would like to enroll in the prescription drug coverage for $23.20 per month.

❑ **No**, I do not want to enroll in prescription drug coverage through HealthPartners.

If you select a prescription drug option outside of a Medicare-approved enrollment period, that portion of your application may be rejected.

SECTION THREE: Billing selection

Choose **ONE** payment option:

❑ Monthly Direct Payment (electronic fund transfer from your bank account)
Please complete the enclosed Direct Payment Authorization form and return it with this application.

❑ Monthly Paper Billing ❑ Quarterly Paper Billing

❑ Automatic deduction from your monthly SSA benefit check
The SSA deduction may take three or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.You cannot select this option if your total monthly premium is $200 or more.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75 percent of your drug costs and not be subject to the coverage gap or late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information, contact your local Social Security office or call Social Security at 1-800-772-1213. TTY 1-800-325-0778. Or you can apply at socialsecurity.gov/prescriptionhelp.

SECTION FOUR: Medicare information

Please take out your Medicare card to complete this section.

Please fill in the blank card to the right so it matches your red, white and blue Medicare card.

OR

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

Health Insurance

SOCIAL SECURITY ACT

NAME OF BENEFICIARY ______________________

CLAIM NUMBER ______________ SEX ______

IS ENTITLED TO — EFFECTIVE DATE

HOSPITAL INSURANCE (PART A) ______________

MEDICAL INSURANCE (PART B) ______________

SECTION FIVE: Please answer the following questions

❏ YES ❏ NO Do you have End Stage Renal Disease (ESRD)? ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive. If your answer is YES, you cannot enroll in this plan unless 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. If you have ESRD, you cannot enroll in this plan unless you are already enrolled in a HealthPartners plan as a commercial member.

❏ YES ❏ NO Are you currently enrolled in another Medicare health plan that you intend to keep in addition to the HealthPartners® Wisconsin Freedom plan (Cost)? If YES, please include the insurance name and address and policyholder name and number. ____

____

Typically you may enroll in a Medicare Prescription Drug plan during the annual enrollment period between November 15 and December 31 of each year. However, there are exceptions that may allow you to enroll in a Medicare Prescription Drug plan outside of these periods. Some of the questions below will help us determine which enrollment period you are enrolling under.

Many people can join in this plan and keep the current prescription coverage that they already have. This includes other private insurance, Worker's Compensation, TRICARE, VA benefits, State assistance programs, and any other coverage you may have for your prescriptions. In order for Medicare to coordinate these benefits, please list any current coverage you have for prescription drugs that you plan to keep.

❏ YES ❏ NO I plan to keep additional prescription coverage.

If YES, what is the name of the company providing your other coverage? ______________________

What is your identification number (ID number) for this coverage? ______________________

❏ YES ❏ NO Do you live in a long term care facility (for example, a nursing home)?

If YES, Name of Institution: ______________________

Address of Institution (number and street): ______________________

Phone Number of Institution: ______________ Your Date of Admission: ______________

❏ YES ❏ NO Did you recently move "out" of a long term care facility (for example, a nursing home)?
If YES, when did you move "out"?______________(MM/DD/YYYY)

SECTION FIVE (continued)

❏ YES ❏ NO Do you have both Medicare and Medicaid or does the state help pay for your Medicare premiums?

❏ YES ❏ NO Are you either losing coverage you had from an employer or leaving employer coverage?
If YES, when does this coverage end ?______________(MM/DD/YYYY)
Please check with your benefits administrator about any decision to join another health plan.
Joining one could affect your employer or union health benefits.

❏ YES ❏ NO Did you recently move outside the service area of your current healthcare plan?
If YES, what was your move date?______________ (MM/YYYY)

❏ YES ❏ NO Do you receive extra help paying for Medicare prescription drug coverage?

❏ YES ❏ NO Are you now or have you ever been a HealthPartners member?
If YES, please give your identification number (to avoid duplication): ____________________________

❏ YES ❏ NO Do you receive Medicaid benefits?
If YES, what is your Medicaid number? ____________________________

Please read this important information

If you are in a Medicare Advantage Plan (like an HMO or PPO), joining the HealthPartners® Wisconsin Freedom Medicare Prescription Drug Program (Cost) means that you will no longer be in your Medicare Advantage plan. You don't have to do anything to cancel your membership in your Medicare Advantage plan. By joining the HealthPartners® Wisconsin Freedom Medicare Prescription Drug Program (Cost), you will now get your healthcare from the HealthPartners® Wisconsin Freedom plan (Cost). You should call your health plan if you are unsure if you have a Medicare Advantage plan.

Release of Information: By joining this Medicare health plan, I acknowledge that HealthPartners will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that HealthPartners will release my information, including my prescription drug event data, to Medicare if applicable, 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 the 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 HealthPartners or Medicare.

Stop! Please read this important information.

If you currently have health coverage from an employer or union, joining the HealthPartners® Wisconsin Freedom plan (Cost) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join our plan. 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.

Signature ____________________________________ Today's Date: ____________________________________
(Enrollee or authorized representative)

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

Name ______________________________ Address ____

Phone Number (______) ________________ Relationship to Enrollee ______________________________