



# Contact HealthPartners Medicare Sales

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## By Phone

For questions about your medical or dental plan options, call Medicare Sales at 952-883-5600 or 1-877-207-1214, 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](mailto:medicaresales@healthpartners.com).

## On the Web

Find more information or print off additional copies of this application at [healthpartners.com/medicare](http://healthpartners.com/medicare).

Return application in the enclosed postage-paid envelope to:

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

Or fax it to 952-853-8746.

HealthPartners is a health plan with a Medicare contract.



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

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## Classic Plan (HMO) Enrollment Form

### You are eligible to join HealthPartners<sup>®</sup> Classic plan (HMO) if:

- 1) You are enrolled in the Federal Medicare Program for Part A (hospital coverage) and Part B (medical coverage); and
- 2) You live in the plan's service area; and
- 3) You DO NOT have End Stage Renal Disease (ESRD). ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive. If you have ESRD, you cannot enroll in this plan unless you are already a commercial member of HealthPartners and developed ESRD while you were a non-Medicare member; and
- 4) You are enrolling during an approved enrollment period. (See Section Five for additional information.)

### To apply, please follow these steps:

- 1) Each individual must complete a separate enrollment form. Fill out ALL of the enrollment form except the shaded areas. Incomplete or incorrect enrollment forms may delay the effective date of your coverage. Use a ball point pen and press firmly to ensure clear carbon copies.
- 2) Please provide a PHOTOCOPY of your Medicare card with this enrollment form. If you do not have your card yet, send a copy of the written verification that you received from the Social Security Office.
- 3) Select a medical clinic and a dental clinic. (See the enclosed network information for providers or search on [healthpartners.com](http://healthpartners.com).) If you do not select a clinic, HealthPartners will assign one near your permanent address for you.
- 4) **Carefully read, sign and date the enrollment form.**
- 5) **Retain the second copy for your records.** Send the first copy to HealthPartners in the enclosed postage-paid envelope.

### Important information:

- 1) After we receive your enrollment form, we will send you a member identification card and letter stating when your coverage begins.
- 2) If you would like your HealthPartners premiums to be paid directly from a bank account, complete the Authorization for Direct Payment form enclosed in this packet and attach a voided check or savings deposit slip.
- 3) Beginning on your effective date, you should use your HealthPartners<sup>®</sup> Classic plan (HMO) member identification card when obtaining services. Keep your Medicare card in a safe place. Providers in the HealthPartners<sup>®</sup> Classic plan (HMO) network will deliver or authorize all of your care. Neither HealthPartners nor Medicare will pay for services you get outside the network, except when you need emergency care, urgent care, renal dialysis or when you use your travel benefit as indicated in the Summary of Benefits.
- 4) By joining this plan you will automatically be enrolled in a Medicare Prescription Drug (Part D) plan.
- 5) 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/prescription help](http://socialsecurity.gov/prescription-help).

Medicare beneficiaries may enroll in this plan through the Centers for Medicare and Medicaid Services (CMS) Online Enrollment Center, located at [medicare.gov](http://medicare.gov). For more information contact HealthPartners at the numbers on the back of this form.

This document is available in alternative formats and languages. Please contact Medicare Sales at the numbers on the back for more information.

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SECTION ONE: Personal Information					
Last Name		First Name		M.I.	Sex <input type="checkbox"/> M <input type="checkbox"/> 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 # \_\_\_\_\_

**RECEIVED**

**SECTION TWO: Clinic selection and billing options**

Please select a medical and dental clinic to be your primary clinic(s) where you will seek primary care services.

Medical Clinic \_\_\_\_\_ Clinic Number \_\_\_\_\_

Dental Clinic \_\_\_\_\_ Clinic Number \_\_\_\_\_

**Choose ONE billing option:** The monthly premium is \$427.20 (Generally you must stay with the option you choose for the rest of the year. If you do not select a payment option, you will receive a bill each month.)

Monthly Direct Payment

To enroll, please complete the enclosed Direct Payment Authorization form and return it to HealthPartners with your enrollment application.

Monthly Paper Billing

Quarterly Paper Billing

**SECTION THREE: Please answer the following questions**

- YES  NO 1. Do you have End Stage Renal Disease (ESRD)? If YES and you don't need regular dialysis any more or if you 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.
- YES  NO 2. Are you a resident in a long term care facility such as a nursing home? If YES, please provide the following information: name, address, phone number of the institution, and your admission date.  
\_\_\_\_\_
- YES  NO 3. MEDICAID ELIGIBILITY: Are you enrolled in your state Medicaid program? If YES, please print the eight-digit Medical Assistance/I.D. number from your Minnesota Health Care Program Card: \_\_\_\_\_
- YES  NO 4. Are you now or have you ever been a HealthPartners member? If YES, please give your member identification number (to avoid duplication): \_\_\_\_\_
- 5. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employees health benefits coverage, VA benefits or state pharmaceutical assistance programs.
- YES  NO Will you have other prescription drug coverage in addition to the HealthPartners® Classic plan (HMO)?  
If YES, please print name for your other prescription drug coverage: \_\_\_\_\_  
Identification number for your other prescription drug coverage: \_\_\_\_\_  
Group number for your other prescription drug coverage: \_\_\_\_\_


## 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 Social Security or the 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: Authorization and acknowledgement

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

The HealthPartners® Classic plan (HMO) 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 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 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. (For example, from November 15 to December 31 of each year.) I may also leave under certain special circumstances.

HealthPartners® Classic plan (HMO) serves a specific service area. (See the Summary of Benefits for more details.) If I move out of the area that the Classic 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 Classic 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 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 if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

I understand that beginning on the date my HealthPartners® Classic plan (HMO) coverage starts I must get all of my healthcare services from HealthPartners, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by HealthPartners and other services contained in my Classic plan EOC will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTHPARTNERS 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 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.

By joining this plan, 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.

**SECTION SIX: Employment information (Required by the Centers for Medicare and Medicaid Services)**

**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, 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 by Medicare.

**Stop! Please read this important information.**

**If you currently have health coverage from an employer or union, joining the HealthPartners® Classic plan (HMO) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join HealthPartners® Classic Plan (HMO).** 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 \_\_\_\_\_

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