HealthPartners®

MedicareRx
Prescription Drug Coverage

Individual HealthPartners® Freedom Plan (Cost) Enrollment Form — Minnesota

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

Step 1: Determine if you're enrolling in medical, prescription drug and/or dental 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 three medical plans. If you choose Medical Plan I, you are not eligible for prescription drug or dental coverage.

- **Freedom Plan I**
- **Freedom Plan II**
- **Freedom Plan III**

Step 3: If you have chosen Medical Plan II or III, you can select optional prescription drug and/or dental plans as well. There are two prescription drug options available:

- **Standard – Available to Medical Plan II and III enrollees**
- **Enhanced – Available to Medical Plan III enrollees only**

You can select a drug plan only if an enrollment election period is available. If you select drug coverage outside of a Medicare-approved enrollment period, the prescription drug plan selection portion of your application may be rejected. For more information, please call Medicare Sales at the numbers on 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 or III to enroll in prescription drug coverage or optional dental plan. You need Medicare Parts A and/or B to enroll in Part D.
- 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 (even if you stay within your current city or county), 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 can only 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 whichever option you choose for the full plan year. Please note that if you switch between direct bill and Social Security premium withhold at any point, it could take up to two months for the change to take effect and you will continue to be held responsible for premium payments during the transition.
- 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.

HealthPartners® Freedom Individual Plan Enrollment Form - Minnesota

SECTION ONE: Personal information

Broker Name _____

Agency # _____

HealthPartners Use Only

Effective Date _____

MR # _____

Ctrct # _____

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):		

SECTION TWO: Plan selection

I am applying for: (Please note: you may only select one medical plan and options under that plan.)

❑ **Freedom Medical Plan I** – $61 per month

❑ **Freedom Medical Plan II** – $93 per month
- ❑ with Standard Prescription Drug Plan – $11.60 per month
- ❑ with Optional Comprehensive Dental Benefit – $37.80 per month

❣ **Freedom Medical Plan III** – $134 per month
- ❑ with Standard Prescription Drug Plan – $24.90 per month
- ❣ with Enhanced Prescription Drug Plan – $199.80 per month
- ❣ with Optional Comprehensive Dental Benefit – $37.80 per month

HealthPartners must receive your completed, signed and dated enrollment form no later than the last working day of the month before you want coverage to begin. Coverage always begins the first day of the following month.

I would like coverage to start:_____(MM/YYYY). We will accommodate your requested effective date as best we can while still following Medicare guidelines.

SECTION THREE: Billing selection

Choose ONE payment option (If you don't select an option, you will get a bill each month.):

- ◯ 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 Social Security (SS) benefit check
  The SS deduction may take two or more months to begin. In most cases, the first deduction from your SS 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. If you enroll in the dental benefit, it cannot be billed through SS deduction. You will receive a separate invoice.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75 percent or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will 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 about this extra help contact your local Social Security office or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at **www.socialsecurity.gov/prescriptionhelp**.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

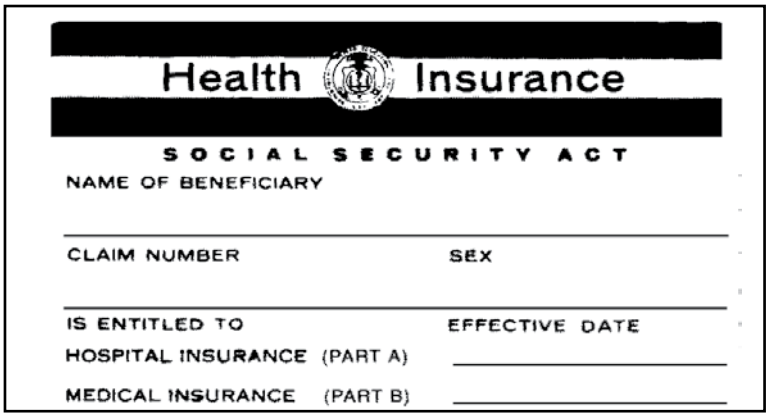
SECTION FOUR: Medicare information

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® Freedom plan? 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 Pharmaceutical 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?
If YES, what is your Medicaid number? _____

❑ YES ❑ NO Are you either losing coverage you or your spouse 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): _____

Stop! Please read section six on page four and this important information below.

I**f you currently have health coverage from an employer or union, joining the HealthPartners® Freedom plan 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.

If you are in a Medicare Advantage Plan (like an HMO or PPO), joining the HealthPartners® Freedom Medicare Prescription Drug Plan 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® Freedom Medicare Prescription Drug Plan, you will now get your healthcare from the HealthPartners® Freedom plan. 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.

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

Name _____ Address _____

Phone Number (_____) _____ Relationship to Enrollee _____

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

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

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

HealthPartners® Freedom plan 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® Freedom plan 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® Freedom plan 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® Freedom plan 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.

Contact HealthPartners Medicare Sales

By Phone
For questions call Medicare Sales at 952-883-5601 or 1-800-247-7015, 8 a.m. to 8 p.m., seven days a week. 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.

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