RETIREE GROUP HEALTH PLAN ENROLLMENT REQUEST FORM

Please contact SCAN Health Plan® if you need any information in another language or format. (Braille)

STEP 1: Please fill out the application completely. Use a ballpoint pen and press hard to make two copies.

STEP 2: Sign and date the application.

STEP 3: Keep the BOTTOM copy for your file.

If you have any questions regarding this application, please call 1-877-212-7654 (TTY: 711). Hours are 8 a.m. to 8 p.m., 7 days a week from October 1 to March 31. From April 1 to September 30 hours are 8 a.m. to 8 p.m., Monday through Friday. Messages received on holidays and outside of our business hours will be returned within one business day.

1 To Enroll in SCAN Health Plan, Please Provide the Following Information:

Retiree Group Number:	Group Number:
Last Name:	
First Name:	M.I. (optional)
Birth Date: M M / D D / Y Y Y Y	Sex: ☐ Male ☐ Female
Phone Number: ( ) -	
Permanent Residence Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):	
City:	State: ZIP Code:
Mailing Address (only if different from your Permanent Address):	
Street Address:	
City:	State: ZIP Code:
Emergency Contact: (optional)	
Phone Number: ( ) -	Relationship to You:

2 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.	Name (as it appears on your Medicare card): Medicare Number:
Social Security: _ _	

3 Please Read and Answer These Important Questions

1.	Are you the retiree? If yes, retirement date (month/date/year): _____ If no, name of retiree:_____	☐ Yes ☐ No
2.	Are you covering a spouse or dependents under this employer or union plan? If yes, name of spouse: _____ Name(s) of dependent(s): _____ ** A separate application is required for a spouse or dependent for enrollment in SCAN Health Plan.	☐ Yes ☐ No
3.	Do you work? Does your spouse work?	☐ Yes ☐ No ☐ Yes ☐ No
4.	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 SCAN Health Plan? If "yes" please provide the following information: Name of other coverage:_____ ID # for other coverage: _____	☐ Yes ☐ No
5.	Are you a resident in a long-term care facility, such as a nursing home? If "yes" please provide the following information: Name of Institution:_____ Address & Phone Number of Institution (number and street): _____ _____	☐ Yes ☐ No

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. Please call SCAN Member Services at 1-800-559-3500. TTY: 711.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay SCAN Health Plan the Part D-IRMAA. For more information about contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users call 1-800-325-0778.

4 Physician Information

Please choose a Primary Care Physician (PCP), and Medical Group.	
I do not have a preferred primary care physician. Please auto assign to a contracted SCAN primary care physician. ☐ Yes ☐ No	
Physician Name:	Physician ID Number: ☐☐☐☐☐☐☐ - ☐☐
Medical Group Name:	Group ID Number: ☐☐☐☐☐
Are you a current patient of this physician? ☐ Yes ☐ No	

5 Answer these important questions:

The fields in this section are optional. Answering these questions is your choice. You can't be denied coverage you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ I choose not to answer.

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Cambodian
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Filipino
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Korean
- ☐ Samoan
- ☐ Vietnamese
- ☐ Other Pacific Islander
- ☐ Mixed Race
- ☐ **I choose not to answer.**
- ☐ White
- ☐ Unknown

What's your gender identity? Select one.

- ☐ Male
- ☐ Female
- ☐ Transgender Male
- ☐ Transgender Female
- ☐ A gender that's not listed _____
- ☐ Not sure
- ☐ **I choose not to answer.**

What's your sexual orientation? Select one.

- ☐ Lesbian
- ☐ Gay
- ☐ Straight - Heterosexual
- ☐ Bisexual
- ☐ A sexual orientation that's not listed _____
- ☐ Not sure
- ☐ **I choose not to answer.**

What are your pronouns? Select one.

- ☐ He/Him
- ☐ She/Her
- ☐ They/Them
- ☐ Other _____
- ☐ **I choose not to answer.**

Email Opt-In: Email Address: _____

I want to get the following materials via email:

☐ By providing my email address, I agree to receive my SCAN materials online rather than by U.S. Mail. I understand this would include documents such as the Part C and Part D Explanation of Benefits (EOB), Annual Notice of Change (ANOC) and I can change back to U.S. mail at any time.

Texting Opt-in: Mobile Number: (| | |) | | | - | | | | |

* By providing my number, I agree to receive automated and/or other text messages by SCAN Health Plan for healthcare, benefits, or any other purpose. Such consent is not a condition of receipt of any service and I can opt out at any time. Msg and data rates may apply.

Language Preferences:

Select one if you want us to send you information in a language other than English:
☐ Spanish ☐ Chinese ☐ Korean ☐ Vietnamese

What is your preferred spoken language if other than English:
☐ Spanish ☐ Cantonese ☐ Mandarin ☐ Korean ☐ Vietnamese

Select one if you want us to send you information in an accessible format: ☐ Braille ☐ Large print ☐ Audio CD

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6 Please Read and Sign Below

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

SCAN Health Plan 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. I understand that if I don't have Medicare prescription drug coverage, or creditable 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. 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 (Example: October 15–December 7 of every year), or under certain special circumstances.

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

Release of Information: By joining this Medicare health plan, I acknowledge that SCAN will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that SCAN 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:_____ Relationship to enrollee:_____

Address:_____

Phone number: (____)_____

FOR INDIVIDUALS HELPING ENROLLEE WITH COMPLETING THIS FORM ONLY		
Complete this section if your an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.		
NAME:	RELATIONSHIP TO ENROLLEE:	SIGNATURE:
EFFECTIVE DATE OF COVERAGE: __ __/__ __ /__ __ __ __ MM DD YYYY	REC'D DATE:	NATIONAL PRODUCER NUMBER (NPN):