RetireeFirst Humana PPO $0

MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM

CALIFORNIA SCHOOLS VEBA

SPONSORED GROUP PLAN

To enroll in Humana® Group Medicare (MAPD) please provide the following information:

Group Number: 335158 Desired Effective Date: _____

LAST Name:	FIRST Name:	MIDDLE Initial:	Mr. Mrs. Ms.

Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: M F	Social Security Number:	Home Phone Number: ( )

Permanent Residence Street Address:

City:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):
Street Address: City: State: ZIP Code:

Email Address:

Phone Number (Optional

Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete.

- Please fill in these blanks so they match 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.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Name: _____

Medicare Beneficiary Identifier (MBI)

__ __ __ __ - __ __ __ - __ __ __ __

Is Entitled To	Effective Date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

PLEASE READ THIS IMPORTANT INFORMATION

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

The Humana Group Medicare PPO plan is a Medicare Advantage plan that has a contract with the federal government and I will need to keep my Medicare Parts A and B to stay in the plan. I must continue to pay my Medicare Part B premium. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare Advantage health plan. It is my responsibility to inform Humana 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.** I understand that if I leave this Humana plan, I may not be eligible to return to the group plan or change plans outside of the group's open enrollment period. I can receive details of my options by calling my plan administrator or customer service.

I understand that when my coverage begins, I must get all of my medical and prescription drug benefits when applicable, from Humana. Benefits and services provided by Humana and contained in my "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Humana will pay for benefits or services that are not covered. I will abide by the rules of my Evidence of Coverage. Once I am a member of Humana, I have the right to appeal plan decisions about payment or services if I disagree.

This Humana plan serves a specific service area. If I move out of the area that this Humana plan serves, I need to notify Humana as I may have to disenroll and find a new plan in my new area. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.

I understand that I am enrolling into a Humana Medicare Advantage plan and not a Medicare Supplement, Medigap, Medicare Select or Medicaid plan.

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.

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Release of Information:

By joining this Medicare plan, I acknowledge that Humana will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement below).

Privacy Act Statement:

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. **Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.**

Individuals experiencing homelessness:

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security benefit checks) may be considered your permanent residence address.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), 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 the Railroad Retirement Board. Do NOT pay Humana the Part D-IRMAA.

Signature:	**Today's Date:**

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OPTIONAL INFORMATION

Answering these questions is your choice.
You can't be denied coverage because 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 origin
- Yes, Puerto Rican
- Yes, Cuban
- Yes, another Hispanic, Latino/a, or Spanish
- **I choose not to answer**

What is your race? Select all that apply.

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

Select if you want us to send you information in a language other than English.

- Spanish

Select one if you want us to send you information in an accessible format.

- Braille
- Large print

Go paperless! Reduce your clutter and help the environment.

I prefer that you send materials to me via email, if available. I understand that I can switch my preference back to mail at any time.

E-mail address: