Liberty Health Advantage

335 West 16th Street, 4th Floor, New York, NY 10011 • 1 (866)-542-4269 TTY: 1-(800)-662-1220

To Enroll in Liberty Health Advantage, Please Provide the Following Information:

Please check which plan you want to enroll in:

_____ Preferred Choice $0 per month
_____ Dual Power Nassau $0 per month
_____ Dual Power-NYC $0 per month
______ Secure Choice $0 per month

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: *(providing this information is optional)*	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:

Emergency contact: ____

Phone Number: (____)________________ **Relationship to You** ________________________

Please Provide Your Medicare Insurance Information

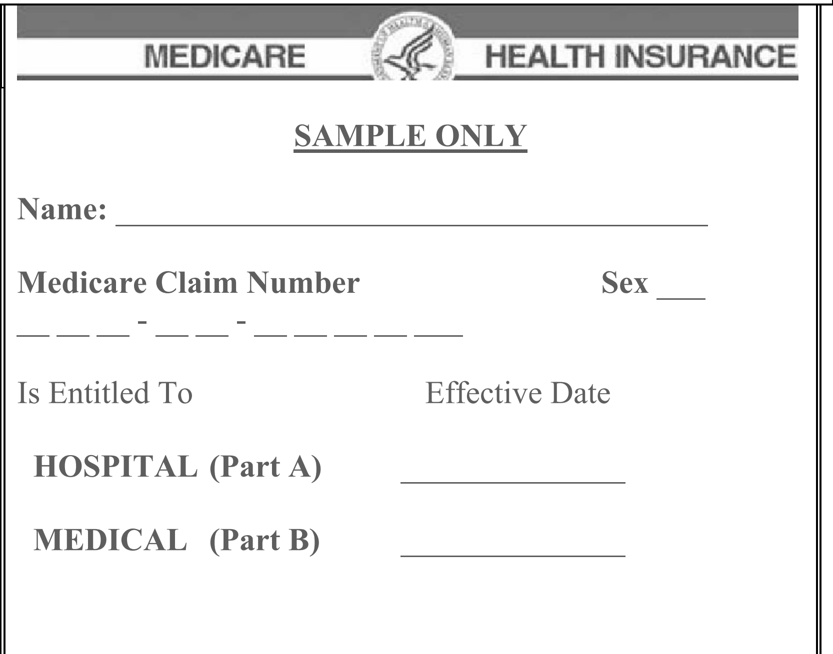
Please take out your Medicare Card to complete this section.

- 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 and Part B to join a Medicare Advantage plan.


MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: ____________________________________

Medicare Claim Number Sex ___

__ __ __ - __ __ - __ __ __ __ ___

Is Entitled To Effective Date

HOSPITAL (Part A) ______________

MEDICAL (Part B) ______________

Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? ☐Yes ☐No

If you answered "yes" to this question and 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.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Liberty Health Advantage? ☐Yes ☐No
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: ________________ ID # for this coverage: ________________ Group # for this coverage ________________

3. Are you a resident in a long-term care facility, such as a nursing home? ☐Yes ☐No

If "yes" please provide the following information: Name of Institution: ____________

Address & Phone Number of Institution (number and street):____
____

4. Are you enrolled in your State Medicaid program? ☐Yes ☐ No

If yes, please provide your Medicaid number: ____

5. Do you or your spouse work? ☐Yes ☐No

Please Choose a Primary Care Physician (PCP):

Name:____

Provider ID#:____

Address:____

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Liberty Health Advantage could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Liberty Health Advantage may change how your current coverage works. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

(Initial)________

Please Read and Sign Below:

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

Liberty Health Advantage is a Medicare Advantage plan and I will need to keep my Parts A and B. I can be in only one Medicare Advantage 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. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Liberty Health Advantage or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

(Initial)________

Liberty Health Advantage serves a specific service area. If I move out of the area that Liberty Health Advantage 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 Liberty Health Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Liberty Health Advantage when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. 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.

(Initial)________

I understand that beginning on the date Liberty Health Advantage coverage begins, I must get all of my health care from Liberty Health Advantage, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Liberty Health Advantage and other services contained in my Liberty Health Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR LIBERTY HEALTH ADVANTAGE WILL PAY FOR THE SERVICES.**

(Initial)________

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Liberty Health Advantage 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 behalf of the individual under the laws of the State where the individual resides) 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 Liberty Health Advantage or by Medicare.

(Initial)_______

Your Signature:	**Today's Date:**

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

Name : ___________________________________ Phone Number: (___) ____- _____

Address: ____

Relationship to Enrollee ___________________

Office Use Only:

Name of staff member (if assisted in enrollment):__________________________

Plan ID #:_____________________________

Effective Date of Coverage: _______________

ICEP/IEP: __________ OEP: __________ AEP: __________ SEP (type): __________ Not Eligible: __________