

# Liberty Health Advantage



1 Huntington Quadrangle, Suite 3N01, Melville, NY 11747 • 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: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number: <i>(providing this information is optional)</i>	Home Phone Number: ( ) Alternative Phone Number: ( )
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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 \_\_\_\_\_

E-mail Address: \_\_\_\_\_

## Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.



### SAMPLE ONLY

Name: \_\_\_\_\_

Medicare Claim Number \_\_\_\_\_ Sex \_\_\_\_\_

Is Entitled To \_\_\_\_\_ Effective Date \_\_\_\_\_

HOSPITAL (Part A) \_\_\_\_\_

MEDICAL (Part B) \_\_\_\_\_

- 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.

**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#:** \_\_\_\_\_ **Provider Phone #** \_\_\_\_\_

**Address:** \_\_\_\_\_

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

\_\_\_\_\_ Spanish \_\_\_\_\_ Large Print



### 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.

### Please Read and Sign Below:

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

Liberty Health Advantage is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my 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 (Example: November 15 – December 31 of every year), or under certain special circumstances.

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.

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.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Liberty Health Advantage, he/she may be compensated based on my enrollment in Liberty Health Advantage.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

**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.

**Your Signature:**

**Today's Date:**

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

**Name :** \_\_\_\_\_ **Phone Number:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Address:** \_\_\_\_\_

**Relationship to Enrollee** \_\_\_\_\_

**Office Use Only:**

Name of staff member /agent /broker (if assisted in enrollment): \_\_\_\_\_

Plan ID #: PC 001 \_\_\_\_\_ DP-Nassau 002 \_\_\_\_\_ DP- NYC 003 \_\_\_\_\_ SC 004 \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

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

- Copy of Medicare Card
- Copy of Medicaid Card
- Copy of EPIC Card
- Copy of LIS Documentation
- Copy of Signed EPIC application
- Letter from Beneficiary
- Other: \_\_\_\_\_

*Telephonic Enrollment Data*    *Date* \_\_\_\_\_ *Time* \_\_\_\_\_ *Verification Agent* \_\_\_\_\_