

Easy Choice Medicare Advantage Plans

— Individual Enrollment Form —

How to Enroll with Easy Choice

- ① Please contact Easy Choice if you need an enrollment form or information in another language or format (Braille or large print). The toll-free number for Customer Service is listed on the cover of this form.
- ② Please read this entire enrollment form to make sure you understand the information.
- ③ When you're ready, fill out the entire enrollment form. Where appropriate, write clearly in block letters or select the appropriate box.
- ④ Once you're done, don't forget to sign and date it.
- ⑤ Return the completed/signed form to Easy Choice using the attached postage-paid business reply envelope.
- ⑥ Contact your Sales Agent with any questions you may have.

Sales Agent: _____ Phone: (____) ____ - _____

3 Other Easy Ways to Enroll with Easy Choice



Call Easy Choice Customer Service at **1-866-999-3945**.

TTY users should call **1-800-735-2929**.

Hours of operation are Monday–Friday, 8 a.m. to 8 p.m.

Between October 1 and February 14, representatives are available Monday–Sunday, 8 a.m. to 8 p.m., or visit us anytime at www.easychoicehealthplan.com.



Enroll online at www.easychoicehealthplan.com.



Enroll online at www.medicare.gov.



2015 EASY CHOICE MEDICARE ADVANTAGE PLANS INDIVIDUAL ENROLLMENT FORM

Please contact Easy Choice if you need information in another language or format (Braille).

To Enroll in an Easy Choice Plan, Please Provide the Following Information:

Please select the box for the plan you want to enroll in:

- | | |
|---|---|
| <input type="checkbox"/> 010: Easy Choice Value Plan (HMO) - Fresno, San Joaquin | <input type="checkbox"/> 005: Easy Choice Best Plan (HMO) - Los Angeles, Orange |
| <input type="checkbox"/> 011: Easy Choice Best Plan (HMO) - Alameda | <input type="checkbox"/> 017: Easy Choice Plus Plan (HMO) - Los Angeles |
| <input type="checkbox"/> 012: Easy Choice Best Plan (HMO) - San Diego | <input type="checkbox"/> 018: Easy Choice Plus Plan (HMO) - Fresno |
| <input type="checkbox"/> 014: Easy Choice Best Plan (HMO) - Santa Clara | <input type="checkbox"/> 001: Easy Choice Freedom Plan (HMO SNP) - Los Angeles |
| <input type="checkbox"/> 015: Easy Choice Best Plan (HMO) - Stanislaus | <input type="checkbox"/> 020: Easy Choice Access Plan (HMO SNP) - Fresno, San Joaquin, Stanislaus |
| <input type="checkbox"/> 016: Easy Choice Best Plan (HMO) - Riverside, San Bernardino | |
| <input type="checkbox"/> 002: Easy Choice Plus Plan (HMO) - Alameda, Orange, Riverside, San Bernardino, San Diego, San Joaquin, Santa Clara, Stanislaus | |

\$ per month

Mr. Mrs. Ms. Last Name:

First Name: Middle Initial:

Birth Date: Sex: M F Home Phone Number:
M M D D Y Y Y Y

Alternate Phone Number:

Permanent Residence Street Address: (P.O. Box is not allowed)

County:

City: State: ZIP Code:

Mailing Address: (only if different from your Permanent Residence Street Address)

Street Address:

City: State: ZIP Code:

Emergency Contact: (optional)


Phone Number: (optional) Relationship to You: (optional)

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 Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage Plan.

	
MEDICARE	HEALTH INSURANCE
SAMPLE ONLY	
Name: <input type="text"/>	
Medicare Claim Number: <input type="text"/>	
Sex: <input type="checkbox"/>	
Is Entitled To:	Effective Date: (MMDDYYYY)
HOSPITAL (Part A)	<input type="text"/>
MEDICAL (Part B)	<input type="text"/>

(White: Office Copy Yellow: Member Copy)

Paying Your Plan Premium

If enrolling in a health plan with a \$0 monthly premium: 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. You can pay by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month, if eligible. 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 the RRB. DO NOT pay Easy Choice the Part D-IRMAA.

If enrolling in a plan with a monthly premium: You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month, if eligible. 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 the RRB. DO NOT pay Easy Choice the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% 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 a late enrollment penalty. Many people are eligible for these savings and do not 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. If you don't select a payment option, you will get a monthly bill to pay your premiums.

Please select a premium payment option:

Get a bill monthly Social Security Railroad Retirement Board

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check (if eligible). The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, or approves deductions to begin after the enrollment effective date, we will send you a bill for your monthly premiums.

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Please Read and Answer These Important Questions:

1. Do you have end-stage renal disease (ESRD)? Yes No

If you have had a successful kidney transplant and/or you do not need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you do not need dialysis; otherwise, we may need to contact you to obtain additional information.

2. For MAPD Plans: 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 Easy Choice? 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 of 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:

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 select ONE box for the language in which you prefer to receive information:

English Spanish (where available) Chinese (where available) Korean (where available) Vietnamese (where available)

Please select the box if you prefer to receive information in large print:

Please contact Easy Choice at the Customer Service number listed on the front cover of this booklet regarding the availability of information in a format or language other than what is listed above.

Please choose a primary care physician (PCP), clinic or health center: (First and Last Name of PCP)

ID#

Are you a current patient? Yes No

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Yellow: Member Copy

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and select the box if the statement applies to you. By filling in any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

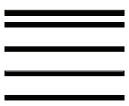
If the statement you select requires a date, please use the following format: MMDDYYYY

- I am a new Medicare beneficiary.
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get Extra Help paying for Medicare prescription drug coverage.
- I no longer qualify for Extra Help paying for my Medicare prescription drugs. I stopped receiving Extra Help on
- I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home). I moved/will move into/out of the facility on
- I recently left a PACE program on
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on
- I am leaving employer or union coverage on
- I belong to a pharmacy assistance program provided by my state or I am losing/recently lost participation in such a program on
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on

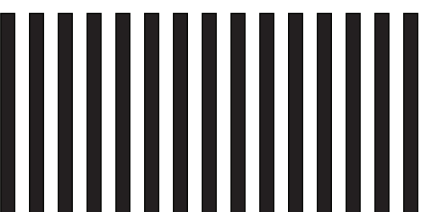
If none of these statements applies to you or you're not sure, please contact Easy Choice at 1-866-999-3945 to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., 7 days a week. TTY users should call 1-800-735-2929.

Yellow: Member Copy
White: Office Copy

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NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



BUSINESS REPLY MAIL

POSTAGE WILL BE PAID BY ADDRESSEE

FIRST-CLASS MAIL PERMIT NO. 9074 TAMPA FL

EASY CHOICE HEALTH PLAN
PO BOX 6025
CYPRESS CA 90630-9807



Remember to ...

- Fill out your application
- Return your completed application in this postage-paid envelope

請記得 ...

- 填妥申請表
- 用隨附的郵資已付的信封寄回填妥的申請表

기억하셔야 할 것들 ...

- 귀하의 지원서 작성하기
- 우표값이 미리 지불된 이 봉투에 작성 완료된 지원서를 넣어 우편으로 보내기

Nên nhớ ...

- Điền đơn xin của quý vị
- Gửi lại đơn đã điền trong phong bì đã trả trước tiền tem

Recuerde ...

- Completar su solicitud
- Enviar su solicitud diligenciada en este sobre con porte postal pago