brand new day
HEALTHCARE YOU CAN FEEL GOOD ABOUT

**To Enroll in a Brand New Day Health Maintenance Organization or Special Needs Plan (SNP), please provide the following information:**

**To Enroll in Brand New Day, Please Provide the Following Information: Select one Plan and one County**

| Plan # and Descriptions: | Plan # and Descriptions: |
|---|---|
| ☐ *025 – **Classic Care** (HMO)*<br>*County:* ☐LA ☐Orange ☐Riverside ☐San Bernardino ☐Kern ☐Kings | $0 |
| ☐ *033 – **Classic Choice for Medi-Medi** (HMO)*<br>*County:* ☐LA ☐Orange ☐Riverside ☐San Bernardino ☐Kern ☐Kings | $31 - *paid by State of California for Medi-Medi members* |
| ☐ *024 – **Dual Coverage** (HMO D-SNP for Medi-Medi coverage)*<br>*County:* ☐LA ☐Orange ☐Riverside ☐San Bernardino ☐Kern | $31 - *paid by State of California for Medi-Medi members* |
| ☐ *026 – **In Control Drug Savings** (HMO Special Needs Plan for Diabetes)*<br>*County:* ☐LA ☐Orange ☐Riverside ☐San Bernardino ☐Kern | $0 |
| ☐ *027 - **In Control Extra Care** (HMO Special Needs Plan for Diabetes)*<br>*County:* ☐LA ☐Orange ☐Riverside ☐San Bernardino ☐Kern | $31 - *paid by State of California for Medi-Medi members* |
| ☐ *028 – **Bridges Drug Savings** (HMO Special Needs Plan for Dementia)*<br>*County:* ☐LA ☐Orange ☐Riverside ☐San Bernardino ☐Kern | $0 |
| ☐ *029 - **Bridges Extra Care** (HMO Special Needs Plan for Dementia)*<br>*County:* ☐LA ☐Orange ☐Riverside ☐San Bernardino ☐Kern | $31 - *paid by State of California for Medi-Medi members* |
| ☐ *030 – **Healthy Heart Drug Savings** (HMO Special Needs Plan for CHF)*<br>*County:* ☐LA ☐Orange ☐Riverside ☐San Bernardino ☐Kern ☐Kings | $0 |
| ☐ *031 – **Healthy Heart Extra Care** (HMO Special Needs Plan for CHF)*<br>*County:* ☐LA ☐Orange ☐Riverside ☐San Bernardino ☐Kern ☐Kings | $31 - *paid by State of California for Medi-Medi members* |
| ☐ *032 - **Hope Drug Savings** (HMO Special Needs Plan for Mental Illness)*<br>*County:* ☐LA ☐Orange ☐Riverside ☐San Bernardino ☐Kern ☐Kings | $0 |
| ☐ *020 - **Harmony Extra Care** (HMO Special Needs Plan for Mental Illness)*<br>*County:* ☐LA ☐Orange ☐Riverside ☐San Bernardino ☐Kern ☐Kings | $31 - *paid by State of California for Medi-Medi members* |

| | | | |
|---|---|---|---|
| Last Name: | First Name: | MI | ☐Mr. ☐Mrs. ☐Ms. |
| Birth Date:<br>(M M / D D / Y Y Y Y) | Sex:<br>□ M □ F | Home Phone Number: | Alternate Phone Number: (Optional) |
| Permanent Residence Street Address (P.O. Box is not allowed): | | | Apt # or Space: |
| City: | State: | Zip Code: | (Optional) County |
| Name of Group Home, Board & Care, or other facility in which applicant resides (if applicable): | | | |
| **Mailing address** (only if different than Permanent Residence Address):<br><br>Street Address: | | | Apt # or Space: |
| City | State | Zip Code: | |
| **Emergency contact name: (optional)** | | | |
| Phone Number: (optional) | Relationship to you: (optional)_____ | | |

Brand New Day (health plan) has my permission to send information to me by email. □ yes □ no
This includes sending my personal health information by email. □ yes □ no
I understand I may change my mind and revoke this permission by calling 866-255-4795 at any time.

My email address is:

**Special Enrollment Period (SEP) -** Member is entitled to SEP because 1) □ Is or has just turned 65 years old; 2) □ Recently moved into service area; 3) □ Recently released from prison; 4) □ Has diagnosis for Chronic Care Special Needs Plan; 5) □ Was involuntarily disenrolled from another plan; 6) □ Loss of Dual Status or SNP Eligibility; 7) □ Other _____

White – Brand New Day; Yellow – Member

## 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 or the Railroad Retirement Board.

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

**MEDICARE HEALTH INSURANCE**

**1-800-MEDICARE (1-800-633-4227)**
SAMPLE ONLY

Name:_____

Medicare Claim Number Sex _____

___

Is Entitled To

Effective Date

**HOSPITAL (Part A)** _____
**MEDICAL (Part B)** _____

## PAYING YOUR PLAN PREMIUM

[**Zero premium MA-PD plans insert the following:** <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, <insert optional methods: "Electronic Funds Transfer (EFT)", each month, optional intervals, if applicable, for example "or quarterly">. 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 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 [insert appropriate plan and/or organization name] the Part D-IRMAA.>] [**MA-only and MAPD plans with premium insert - <You can pay your monthly plan premium *(including any late enrollment penalty that you currently have or may owe)* by mail** <*insert optional methods*: "Electronic Funds Transfer (EFT)", each month <*insert optional intervals, if applicable, for example* "or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.>]

*[**MAPD Plans with premiums insert:** <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 Brand New Day HMO 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 co-insurance. 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 don't 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 bill each month <*optional language in place of "bill each month*": "coupon book" or "payment book">.

**Please select a premium payment option:**

☐ Get a bill

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____
Bank routing number: _____ Bank account number: _____
Account type: ☐Checking ☐ Saving

☐ Automatic deduction from your monthly Social Security *or Railroad Retirement Board (RRB)* benefit check. (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, we will send you a paper bill for your monthly premiums.)

## 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 don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

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 Brand New Day? ☐ 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 facility, such as a nursing home? (e.g. nursing facility, rest home, rehabilitation hospital, convalescent home, etc.)? ☐ 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 the Medi-Cal program? ☐ Yes ☐ No
   If yes, please provide your Medi-Cal (BIC) number: _____

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

6. Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' Compensation, or VA benefits? ☐ Yes ☐ No
   If yes, what kind of insurance do you have? _____
   What is the name of your insurance? _____

7a. *If you selected or **Hope Drug Savings** or **Harmony Extra Care** (for Mental Illness), Plan 032 or 020:*
Have you been diagnosed with a serious persistent mental illness? (for plan 032 or 020 only) ☐ Yes ☐ No

7b. *If you selected **In Control Drug Savings** or **In Control Extra Care** (for Diabetes), Plan 026 or 027:*
Have you been diagnosed with Diabetes? (for plan 026 and 027 only) ☐ Yes ☐ No

7c. *If you selected **Bridges Drug Savings** or **Bridges Extra Care** (for Dementia), Plan 028 or 029:*
Have you been diagnosed with Dementia? (For plan 028 and 029 only) ☐ Yes ☐ No

7d. *If you selected **Healthy Heart Drug Savings** or **Healthy Heart Extra Care** (for CHF), Plan 030 or 031:*
Have you been diagnosed with Congestive Heart Failure / CHF? (For plan 030 or 031 only) ☐ Yes ☐ No

**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 ☐ Vietnamese ☐ Khmer ☐ Armenian ☐ Russian ☐ Korean ☐ Chinese ☐ Other _____

Please contact Brand New Day at 866-255-4795 if you need information in another format or language than what is listed above. Our office hours are 8 a.m. to 8 p.m. Monday - Friday and weekends additionally from October 1 through February 14th annually. TTY users should call 866-321-5955.

## Please choose the name of a Primary Care Physician (PCP), clinic or health center:

**Effective Date of Coverage:** (Note- In general, you may not choose your effective date of coverage. Brand New Day (the "Plan") will let you know when you may begin using plan services):

**Please check which region / county you want to enroll in – check only one box:**

☐ Los Angeles ☐ Orange ☐ Kern ☐ San Bernardino ☐ Riverside ☐ Kings

| Name of chosen Primary Care Physician (PCP), clinic or health center: | PCP Provider Code and/or Region number: |
|---|---|
| Contracting dentist you have chosen (if applicable): | Dental Facility # (if applicable): |


## PLEASE READ THIS IMPORTANT INFORMATION

**If you currently have health coverage from an employer or union, joining Brand New Day could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Brand New Day.** 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 isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

## PLEASE READ, INITIAL AND SIGN BELOW:

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

**1. Brand New Day is a Medicare Advantage HMO 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. 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. _____ ***(Initial)***

**2. Brand New Day serves a specific service area.** If I move out of the area that Brand New Day 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 Brand New Day, **I have the right to appeal plan decisions about payment or services if I disagree**. **I will read the Evidence of Coverage document from Brand New Day when I get it to know which rules I must follow in order to receive coverage** with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered by Medicare while out of the country except limited for coverage near the U.S. border. _____ ***(Initial)***

**3.** I understand that beginning on the date Brand New Day coverage begins**; I must get all of my health care from Brand New Day,** except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Brand New Day and other services contained in my Brand New Day Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, NEITHER MEDICARE NOR BRAND NEW DAY WILL PAY FOR THE SERVICES. _____ *(Initial)***

**4.** I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Brand New Day, he/she may be paid based on my enrollment in Brand New Day. _____ ***(Initial)***

**5. Release of Information:** By joining this Medicare health plan, I acknowledge that Brand New Day will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Brand New Day 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._____ ***(Initial)***

**6.** I understand that **my signature** (or 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. _____ ***(Initial)***

**Signature:** _____ **Today's Date:** _____

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

**Name (Please print):** _____

**Address:** _____ **Phone Number:** _____

**Relationship to Enrollee:** _____

**Documentation Type:** ( ) DPOA ( ) DPAHC ( ) Written Advance Directive ( ) Legal Guardian

If anyone helped the individual fill out this form (with the exception of the effective date), she/he must sign the following line:

**Signature:** _____ **Date:** _____

**Relationship to applicant:** Agent _____ **Agent #**: _____ **FMO:** MP Insurance Solutions _____

**Enroll by:** ☐ Phone-Tracking #_____ ( ) Web-Tracking #_____ ( ) Grp Seminar ☐ In-Home

**Brand New Day HMO Office Use Only:**

Date of Receipt: _____ Date Entered: _____ Plan ID# _____ Initials of Verification Rep: _____

Date E4 Letter Sent out: _____ Date E6 Letter Sent Out: _____Effective Date of Coverage: _____

Name of Staff Member/agent/broker (if assisted in enrollment): _____

Group #: _____ Part D Premium: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ LIS: _____ Not Eligible: _____

Notes:_____

_____

_____

_____

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