3800 Kilroy Airport Way, Suite 100
Long Beach, CA 90806

Individual Enrollment Request Form

Please contact **SCAN Health Plan®** if you need information in another language or format (Braille).

1 To enroll in **SCAN Health Plan**, please provide the following information:

Please check which plan you want to enroll in:

SCAN Classic (HMO)
- ☐ 001 Ventura County $41 per month
- ☐ 006 Los Angeles County $0 per month
- ☐ 007 Orange County $0 per month
- ☐ 008 Riverside County $0 per month
- ☐ 009 San Bernardino County $0 per month
- ☐ 019 San Francisco County $50 per month
- ☐ 020 Santa Clara County $70 per month
- ☐ 046 Marin County $66 per month
- ☐ 052 Napa and Sonoma Counties $0 per month
- ☐ 056 San Joaquin County $50 per month

SCAN Balance (HMO SNP)
- ☐ 034 Los Angeles and Orange Counties $0 per month
- ☐ 048 Marin County $51 per month
- ☐ 054 Napa and Sonoma Counties $21 per month

SCAN Heart First (HMO SNP)
- ☐ 028 Orange County $0 per month
- ☐ 033 Riverside and San Bernardino Counties $0 per month
- ☐ 047 Marin County $51 per month
- ☐ 053 Napa and Sonoma Counties $21 per month

Scripps Classic offered by SCAN Health Plan (HMO)
- ☐ 005 San Diego County $0 per month

SCAN Classic II (HMO)
- ☐ 061 Riverside County $0 per month
- ☐ 062 San Bernardino County $0 per month

Scripps Signature offered by SCAN Health Plan (HMO)
- ☐ 004 San Diego County $69 per month

Scripps Heart First offered by SCAN Health Plan (HMO SNP)
- ☐ 055 San Diego County $26 per month

Scripps Plus offered by SCAN Health Plan (HMO)
- ☐ 040 San Diego County $31.10 per month

SCAN Plus (HMO)
- ☐ 037 Orange County $31.10 per month
- ☐ 045 Los Angeles, Riverside, San Bernardino and San Francisco Counties $31.10 per month

SCAN Healthy at Home (HMO SNP)
- ☐ 006 Los Angeles, Orange, Riverside and San Bernardino Counties $0 per month

SCAN Connections (HMO SNP)
- ☐ 010 Los Angeles, Riverside and San Bernardino Counties $0 per month
- ☐ 057 San Joaquin County $31.10 per month

SCAN Connections at Home (HMO SNP)
- ☐ 029 Los Angeles County $0 per month
- ☐ 030 Riverside County $0 per month
- ☐ 031 San Bernardino County $0 per month

1 To enroll in **SCAN Health Plan**, please provide the following information: *(continued)*

Last Name:

First Name: M.I. ☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date: / / Sex: ☐ Male ☐ Female

M M D D Y Y Y Y

Home Phone Number: ( ) -

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

City: State: ZIP Code:

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

Street Address:

City: State: ZIP Code:

Emergency Contact *(optional)*:

Phone Number: ( ) -

Relationship to you:

E-Mail *(optional)*:

Would you like to receive SCAN materials via E-Mail? ☐ Yes ☐ No

If yes, we will send an E-mail to the address you provide above, with a link to receive your benefit materials online.

2 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:

Medicare Claim Number: Sex: ☐ M ☐ F

- - -

Is Entitled to: Effective Date:

HOSPITAL (Part A): / /

MEDICAL (Part B): / /

3 Paying your **Plan Premium**

You can pay your monthly plan premium, and/or 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, Electronic Funds Transfer (EFT), credit card, or debit card each month. You can also choose to pay 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 RRB. DO NOT pay SCAN the Part D-IRMAA.

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3 Paying your **Plan Premium** *(continued)*

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.

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

☐ **Credit Card/Debit Card.** Please provide the following information: Type of card: ☐ VISA ☐ M/C ☐ AMEX ☐ Discover

Name of Account holder as it appears on card:

Account Number:

Expiration Date: / (MM/YYYY) Security Code:

☐ **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.)

4 Please read and answer these important questions

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

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 SCAN Health Plan?
   ☐ 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:

4 Please read and answer these important questions *(continued)*

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

6. **Complete only if you are enrolling in Heart First. If enrolling in any other plan, skip this question.**
Has your doctor diagnosed you with one of the following conditions?

Congestive Heart Failure	☐ Yes	☐ No	Coronary Artery Disease	☐ Yes	☐ No
Cardiac Arrhythmia	☐ Yes	☐ No	Peripheral Vascular Disease	☐ Yes	☐ No
Chronic Venous Thromboembolic Disorder	☐ Yes	☐ No			

7. **Complete only if you are enrolling in SCAN Balance. If enrolling in any other plan, skip this question.**
Has your doctor diagnosed you with diabetes? ☐ Yes ☐ No

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

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:

Language: ☐ Spanish ☐ Chinese

Format: ☐ Large Print ☐ Audio CD ☐ Electronic Format (E-Mail) ☐ Other Format

Please contact SCAN at 1-800-559-3500 if you need information in another format or language than what is listed above. Our office hours are 8 A.M.–8 P.M., 7 days per week. TTY users should call 711.

5 Please read this **important information**

STOP

If you currently have health coverage from an employer or union, joining SCAN Health Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join SCAN Health Plan. 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.

6 Please **read and and sign below**

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

SCAN Health Plan is a Medicare Advantage 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.

SCAN Health Plan serves a specific service area. If I move out of the area that SCAN Health Plan 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 SCAN, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from SCAN when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

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

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with SCAN, he/she may be paid based on my enrollment in SCAN.

Release of Information: By joining this Medicare health plan, I acknowledge that SCAN will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that SCAN 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 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.

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

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

Name:

Address:

Home Phone Number: (| | |) | | | - | | | |

Relationship to Enrollee:

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 check the box if the statement applies to you. By checking 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.

- ☐ I am new to Medicare.
- ☐ 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 (insert date): ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I recently returned to the United States after living permanently outside of the U.S.
  I returned to the U.S. on (insert date): ☐☐ / ☐☐ / ☐☐☐☐
- ☐ 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 (insert date): ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date): ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I recently left a PACE program on (insert date): ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
  I lost my drug coverage on (insert date): ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I am leaving employer or union coverage on (insert date): ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ 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 (insert date): ☐☐ / ☐☐ / ☐☐☐☐

If none of these statements applies to you or you're not sure, please contact SCAN Health Plan at 1-877-452-5898 (TTY users should call 711) to see if you are eligible to enroll. We are open 8 A.M.–8 P.M., 7 days per week.

OFFICE USE ONLY					
NAME OF STAFF MEMBER/AGENT/BROKER (if assisted in enrollment):					REP. CODE: ☐☐☐☐☐☐☐☐
EFFECTIVE DATE OF COVERAGE: ☐☐ / ☐☐ / ☐☐☐☐ (M M / Y Y Y Y)	ICEP/ IEP:	AEP: ☐	SEP (TYPE): ☐ _____	NOT ELIGIBLE	REC'D DATE: ☐☐ / ☐☐ / ☐☐☐☐
	PLEASE CHECK THE APPROPRIATE BOX(ES) ABOVE				☐ EE DUP CONF#
Supplemental PCP & Medical Group Information					Physician ID Number:
Medical Group Name:					Group ID Number:
Is this the prospective member's current physician? ☐ Yes ☐ No					Plan ID Number: