

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

**To Enroll in Capital Health Plan,
Please Provide the Following Information:**



PLEASE CHOOSE THE PLAN THAT YOU WISH TO JOIN:

- Capital Health Plan Advantage Plus (HMO) \$38.50 per month Capital Health Plan Preferred Advantage (HMO) \$59.60 per month

LAST Name:	FIRST Name:	Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date: (___ / ___ / ___) (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ()	Alternate Phone #: ()
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Permanent Residence Street Address (P.O. Box is not allowed):

City:	State:	ZIP Code:
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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 (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 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	
Name: _____	
Medicare Claim Number	Sex _____
_____ - _____ - _____	_____
Is Entitled To	Effective Date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

Paying Your Plan Premium

You can pay your monthly plan premium by mail or by "Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

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 you 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 does not cover. If you don't select a payment option, you will receive 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 and provide the following:
Account holder name: _____
Bank routing number: _____ Bank account number: _____
Account type: Checking Saving
- Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

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 don't need regular dialysis any more, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't 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 CHP? 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

6. Please choose your primary care physician: _____

Are you an established patient of this primary care physician? Yes No

Please contact Capital Health Plan at 850-523-7441 (TTY users should call 850-383-3534) seven days a week, 8 a.m. to 8 p.m. if you need information in another format or language other than English.



Please Read This Important Information

If you currently have health coverage from an employer or union, joining Capital Health Plan Advantage Plus/Preferred Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Capital Health Plan Advantage Plus/Preferred Advantage. 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 and Sign Below

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

Capital Health Plan Advantage Plus/Preferred Advantage 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: November 15th – December 31st of every year), or under certain special circumstances.

Capital Health Plan serves a specific service area. If I move out of the area that Capital 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 Capital Health Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Capital Health Plan 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 under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Capital Health Plan Advantage Plus/Preferred Advantage coverage begins, I must get all of my health care from Capital Health Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Capital Health Plan and other services contained in my Capital Health Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR CAPITAL HEALTH PLAN 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 Capital Health Plan, he/she may be paid based on my enrollment in Capital Health Plan.

Release of Information: By joining this Medicare health plan, I acknowledge that Capital 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 Capital Health Plan 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 Capital Health Plan or by Medicare.

Signature: _____

Today's Date: _____

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

Name: _____

Address: _____

Phone Number: (____) ____ - _____

Relationship to Enrollee _____

Office Use Only

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

Plan ID : _____

Effective Date of Coverage: _____

Election Type:

IEP(E): _____ ICEP(I): _____ Dual/LIS SEP(U): _____ Perm Chg in Res(V): _____

EGHP SEP(W): _____ Admin. SEP(X): _____ CMS/Case Worker SEP(Y): _____

Other SEP (S): _____ AEP(A): _____ OEP(O): _____

Received Application:

Called Member:

Processed in System:

Submitted to CMS:

Please read and answer these important questions:

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15th and December 31st of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1st and March 31st of each year, as long as you don't add or drop your prescription drug coverage (i.e. if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage: if you don't have Medicare prescription drug coverage you can only change to another plan without Medicare prescription drug coverage.) Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

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 (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 (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 (date): _____
- I recently left a PACE program on (date) _____
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (date): _____
- I am leaving employer or union coverage on (date): _____
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (date): _____
- None of these statements applies to me. *

*Please contact Capital Health Plan at 850-523-7441 (TTY users should call 850-383-3534) to see if you are eligible to enroll. We are available 8 a.m. to 8 p.m. seven days a week.