



8170 33rd Avenue South
PO BOX 1309
Mail Stop 21106D
Minneapolis, MN 55440-1309

Individual HealthPartners® Freedom Medical Plan Enrollment Instructions

Each individual must complete a separate enrollment form.

You are eligible to join HealthPartners Freedom if:

- You are enrolled in the Federal Medicare Program for Part A (hospital coverage) AND Part B (medical coverage) or you are enrolled in Part B only. If you have Medicare Part B only, you will only have coverage for Medicare Part B services. You will not have coverage for hospital, skilled nursing facilities, and related services covered by Medicare Part A; and
- You live in the plan's service area. This eligibility condition does not apply if you are already a commercial member of HealthPartners. However, if you move to a different out-of-area address after the initial enrollment, CMS requires HealthPartners to disenroll you from the plan; and
- You DO NOT have End Stage Renal Disease (ESRD). ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive. If you have ESRD, you cannot enroll in this plan unless you are already a commercial member of HealthPartners and developed ESRD while you were a non-Medicare member; and
- You have NOT elected hospice care (special services for the terminally ill) under Medicare.

Important information:

- After we receive your enrollment form, we will send your member identification card and a letter stating when your coverage begins. HealthPartners must receive your completed, signed and dated enrollment form by the last working day of the month before you want coverage to begin. Coverage always begins on the first day of a future month.

- If you would like your HealthPartners premiums to be paid directly from a bank account, complete the Authorization for Direct Payment in this packet and attach a voided check or savings deposit slip.

OR

You can choose the Premium Withhold option through the Social Security Administration. For more information, contact Medicare.

To enroll, please follow these steps:

- 1) Fill out ALL of the enrollment form except shaded areas. Incomplete or incorrect enrollment forms may delay the effective date of your coverage. Use a ball-point pen and print firmly to ensure clear carbon copies.
- 2) Provide a PHOTOCOPY of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board with this enrollment form. **Or you may fill out the information in Section Three exactly as it appears on your Medicare card.**
- 3) Select one medical plan option:
 - Plan I
 - Plan II
 - Plan III
- 4) **Carefully read, sign and date the enrollment form.**
- 5) **Retain the blue copy for your records.** Send the white copy to HealthPartners in the enclosed postage-paid envelope.

HealthPartners is a health plan with a Medicare contract.

Individual HealthPartners® Freedom Medical Plan Enrollment Form

SECTION ONE: Personal information

Last Name _____ First Name _____ M. I. _____ Social Security Number _____

Date of Birth (MM/DD/YY) _____ Home Phone (area code) _____ Work Phone (area code) _____

Permanent Home Address _____ Apt. No. _____

City _____ State _____ ZIP Code _____ County _____

Mailing Address (if different from permanent home address) _____ Apt. No. _____

City _____ State _____ ZIP Code _____ County _____

Male Female

Broker Name Murray Herstein
Agency No. 1511
HEALTHPARTNERS USE ONLY
Eff. Date _____
MR# _____
Ctrct # _____
Received

SECTION TWO: Medical plan and billing information

Choose **ONE** medical plan option:

- Plan I - \$52
- Plan II - \$80
- Plan III - \$116

To enroll in a HealthPartners® Freedom Medicare Prescription Drug plan, you must also complete the Medicare Prescription Drug Program Enrollment Application that is included in your HealthPartners® Freedom packet.

Choose ONE

HealthPartners billing option:

- Monthly Quarterly Monthly Direct Payment (Complete Authorization Form.)

OR

Premium Withhold:

- Monthly Direct Payment automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month which you can pay by mail or by electronic Funds Transfer (EFT).



Generally you must stay with the option you choose for the rest of the year.

SECTION THREE: Medicare information

Please provide a PHOTOCOPY of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board with this enrollment form.



OR you may fill out the information in section three exactly as it appears on your Medicare card.

Health  Insurance	
SOCIAL SECURITY ACT	
NAME OF BENEFICIARY _____	
CLAIM NUMBER _____	SEX _____
IS ENTITLED TO	EFFECTIVE DATE _____
HOSPITAL INSURANCE (PART A)	_____
MEDICAL INSURANCE (PART B)	_____
SIGN HERE 	

SECTION FOUR: Please answer the following questions

1. Do you have End Stage Renal Disease (ESRD)? ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive. If you answer is YES, you cannot enroll in this plan unless 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. If you have ESRD, you cannot enroll in this plan unless you were already enrolled in a HealthPartners plan as a commercial member or you were affected by the non-renewal of another Medicare Advantage plan after December 31, 1998. YES NO

2. Have you already elected hospice care (special services for the terminally ill) under Medicare? If YES, you cannot enroll in this plan. YES NO

3. Are you currently enrolled in another Medicare health plan that you intend to keep in addition to the HealthPartners® Freedom plan? If YES, please include the insurance name and address and policyholder name and number. By enrolling in HealthPartners® Freedom Plan, you may be canceling your membership in your current plan. Please call HealthPartners if you have questions. YES NO

Your answers to the following questions will not affect your eligibility for enrollment in this plan.

4. Are you now or have you ever been a HealthPartners member? If YES, please give your identification number (to avoid duplication) _____ YES NO

5. Are you a resident of an institution (e.g., skilled nursing facility, rehabilitation hospital)? YES NO
 If yes, Name of Institution _____
 Address of Institution (number and street) _____
 Phone Number of Institution _____
 Your Date of Admission into Institution _____

6. Do you receive Medicaid benefits? YES NO
 If yes, what is your Medicaid number? _____

For MAC use only AEP

OEP

SECTION FIVE: Authorization and acknowledgement

Generally, I can be a member of only one Medicare medical plan and one Medicare Prescription Drug Program at a time. By enrolling in this plan, I will automatically be disenrolled from any other Medicare medical plan, including a Medicare Health Plan (Medicare Advantage and Medicare Cost plans) of which I am currently a member. I understand that since I can be a member of only one Medicare plan at a time, I cannot enroll in more than one Medicare plan with the same effective date of coverage. If I do this, my enrollments may be canceled and I will have to fill out a new enrollment form to become a member of a Medicare plan.

I must keep my Medicare Part A, Part B insurance by paying the premiums.

“Effective date of coverage” is when I should begin using the plan’s services. The plan will still send me final approval of my enrollment in the plan. I understand that I should not disenroll from any Medicare supplement plan, or Medigap or Medicare Select plan until I get that approval from the plan.

Beginning on the date HealthPartners® Freedom Plan coverage begins, I will receive all of my health care from HealthPartners, with the exception of emergency or urgently needed services. In addition to being covered in the United States, emergency and urgently needed services are covered in certain hospitals in Mexico and Canada. If I do not receive care from HealthPartners, I will be liable for all applicable Medicare fees and co-pays. HealthPartners will not cover these services.

There may be times when I may not be able to disenroll from the HealthPartners® Freedom plan. I may disenroll by sending a written request to the plan or by calling 1-800-MEDICARE, (1-800-633-4227) 24 hours a day/7 days a week (TTY: 1-877-486-2048 for the hearing and speech impaired). Until the effective date of disenrollment, I must keep getting health care from the HealthPartners® Freedom plan doctors.

As a member of the plan, I have the right to ask about the plan’s decision about payment or services if I disagree.

I must tell HealthPartners before I move out of the service area. I understand that if I move permanently out of the service area, Medicare requires HealthPartners to disenroll me.

It is my job to tell HealthPartners about other prescription drug coverage I may have. If I intentionally misrepresent this information, Medicare requires the plan to disenroll me.

If I currently have health coverage from an employer or union group, enrolling in other coverage could affect my employer or union health benefits. I should discuss my decision to enroll in a Medicare plan with my benefits administrator.

Release of Information: By joining this Medicare health plan, I allow the Centers for Medicare & Medicaid Services (CMS) to give information to the plan. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B). I also allow the plan’s doctors or clinics or anyone else with medical or relevant information about me to give CMS or CMS’s agents the information needed to run the Medicare program.

I understand that my signature on this application means that I have read and understand the contents of this application. Note: To find out more about the rules and procedures you must follow in order to receive coverage, please read the HealthPartners® Freedom Evidence of Coverage. (This will be sent to you automatically once you are enrolled or upon request.)

Enrollment begins the first day of the month after HealthPartners receives your completed form and verifies your eligibility.

Your Signature* _____ Date _____

* If the individual cannot sign, a court-appointed legal guardian or person with Power of Attorney, if authorized by state law; or another person who is authorized by state law, must sign the following line. Attach a copy of proof of Legal Guardian, Power of Attorney, or proof of authorization by state law.

Signature _____ Date _____

If anyone helped the applicant fill out this form, she or he must sign below:

Please sign here: _____ Relationship: _____ Date: _____

For questions regarding medical and dental plan options, call 952-883-5601 or 1-800-247-7015, Monday - Friday, 8 a.m. to 6 p.m. TTY users should call 952-883-6060 or 1-800-443-0156.

For questions about Medicare Part D prescription drug benefits, including copayments, deductibles and network pharmacies, call 952-883-5601 or 1-800-247-7015, 7 days a week, 8 a.m. to 8 p.m. TTY users should call 952-883-6060 or 1-800-443-0156.



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