Generations Advantage
Focus DC (HMO SNP)
Focused on Diabetes Care

MARTIN'S POINT®
MEDICARE ADVANTAGE PLANS
GENERATIONS ADVANTAGE

Pre-enrollment Qualification Assessment

The Martin's Point Generations Advantage Focus DC (HMO SNP) plan is a Medicare Advantage Special Needs Plan specially designed for people with the chronic condition of diabetes.

Are you eligible to join this plan?

If you can answer "Yes" or "Not sure" to any of the questions below, you may be eligible to join our Special Needs Plan. Martin's Point will need to confirm your chronic condition with your doctor within 30 days of enrollment. If we are unable to do so, we are required to disenroll you from the plan.

Please complete and submit this form with your enrollment application.

First Name:	Last Name:	Middle Initial:

Medicare Claim Number (on your Medicare card):	Birth Date:	Phone Number:
	__ __ (MM) __ __ (DD) __ __ __ __ (Y Y Y Y)	( )

Has your doctor or other licensed professional diagnosed you with diabetes? ☐ **Yes** ☐ **No** ☐ **Not sure**

Have you had problems with high blood sugar? ☐ **Yes** ☐ **No** ☐ **Not sure**

Do you take medication and/or have you been put on a special diet to control your blood sugar? ☐ **Yes** ☐ **No** ☐ **Not sure**

Health care provider(s) who can confirm your chronic condition:

PROVIDER #1	PROVIDER #2
Provider Name:	Provider Name:
Provider Address:	Provider Address:
Provider Phone: ( )	Provider Phone: ( )
Provider Fax: ( )	Provider Fax: ( )

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO VERIFY CHRONIC CONDITION(S):

I hereby authorize the disclosure of my health information by the providers listed above to Martin's Point Generations Advantage to verify that I have been diagnosed with a chronic condition which qualifies me to enroll in a Martin's Point Generations Advantage chronic-care Special Needs Plan. This authorization applies to all health information kept by the provider about my medical history for the chronic condition listed above. **NOTE: Information disclosed due to this authorization will be protected by Martin's Point Generations Advantage in accordance with applicable state and federal laws and requirements.**

Applicant Signature: _____ Date: _____

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Individual Enrollment Form

2020 Focus DC (HMO SNP)

A Medicare Advantage Special Needs Plan Focused on Diabetes Care

Please contact Martin's Point Generations Advantage at 1-888-408-8285 (TTY: 711) if you need information in another language or format.

1 To Enroll in the Martin's Point Generations Advantage Focus DC (HMO SNP) Plan, Please Provide the Following Information:

IMPORTANT NOTE: The Martin's Point Generations Advantage Focus DC (HMO SNP) plan is available for Cumberland County residents only.

The plan includes Part D prescription drug coverage and has a **monthly premium of $0.**

First Name:	Last Name:	Middle Initial:

Birth Date:	Sex:	Primary Phone Number: ( )
__ __ __ __ __ __ __ __ (MM) (DD) (Y Y Y Y)	☐ M ☐ F ☐ Unspecified	Alternate Phone Number: ( ) Email Address*:

Permanent Residence Street Address (PO Box is not allowed):			
City:	State:	ZIP Code:	County:

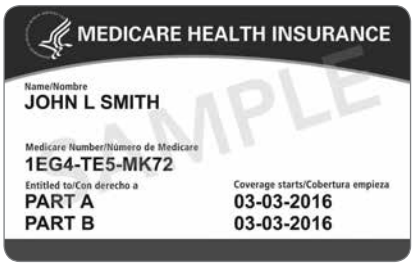
Mailing Address (only if different from your Permanent Residence Address—can include a PO Box):			
City:	State:	ZIP Code:	County:

Emergency Contact Name:	Phone Number: ( )	Relationship to You:

*By providing your email address you are consenting to be contacted via email by the Plan.

2 Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.



- Fill out this information as it appears on your Medicare card.

—OR—

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

NAME: _____

MEDICARE NUMBER: _____

Is Entitled To *Effective Date*

HOSPITAL (Part A): _____

MEDICAL (Part B): _____

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

3 Please Choose Your Primary Care Provider (PCP)

Your PCP must be in the Martin's Point Generations Advantage Focus DC network. If your current PCP is not in this network, you may choose a new in-network PCP or we will designate an in-network PCP for you. A list of PCPs in the Focus DC network is available online at **MartinsPoint.org/Medicare** or by calling Martin's Point Generations Advantage at 1-888-408-8285 (TTY: 711)

Please provide your Focus DC in-network PCP information below:

First Name: _____ **Last Name:** _____

Address: _____

_____

Phone Number: (____)_____

Is this your current physician? ☐ **Yes** ☐ **No**

☐ Please designate a Focus DC in-network Primary Care Provider (PCP) for me.

4 Certify Your 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 enrolling during the Annual Enrollment Period (AEP) from October 15 through December 7 for a plan effective date of January 1, 2020.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) from January 1 through March 31.
- ☐ I am new to Medicare.
- ☐ I am leaving employer or union coverage on ___ /___ /_____.
- ☐ 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 had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on ___ /___ /_____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on ___ /___ /_____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ 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 ___ /___ /_____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ___ /___ /_____.
- ☐ I recently was released from incarceration. I was released on ___ /___ /_____.
- ☐ 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 ___ /___ /_____.
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.
- ☐ I recently obtained lawful presence status in the United States. I got this status 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 ___ /___ /_____.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on ___ /___ /_____.
- ☐ I am enrolling in a 5-Star plan during the 5-Star Special Enrollment Period December 8, 2019 through November 30, 2020.

If none of these statements applies to you or you're not sure, please contact Martin's Point Generations Advantage at 1-888-408-8285 (TTY users should call 711 number) to see if you are eligible to enroll. We are available 8 am–8 pm, seven days a week from October 1 to March 31; and Monday through Friday the rest of the year.

5 Paying Your Part D Late Enrollment Penalty, If You Have One

If we determine that you owe a Part D 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 Electronic Funds Transfer (EFT), credit card, or mail each month. You can also choose to pay your penalty 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 (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay Martin's Point Generations Advantage the Part D IRMAA.

People with limited incomes may qualify for Extra Help (financial assistance from Medicare) to help pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs. Additionally, those who qualify will not be subject to the coverage gap (commonly known as the "donut hole") or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about 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 don't select a payment option, you will get a bill each month by mail.

If you are required to pay a Part D late enrollment penalty amount, please select a payment option:

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get my monthly benefits from:** ☐ Social Security ☐ RRB

(The Social Security or 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.)

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

Name of Account Holder: _____

Bank Routing Number: _____ Bank Account Number: _____

Account Type: ☐ Checking ☐ Savings

☐ **Credit/Debit Card automatically charged each month. Please provide the following information:**

Card Type: ☐ Visa ☐ MasterCard ☐ Other: _____

Name of Account Holder (as it appears on card): _____

Account Number: _____ Exp. Date: ___ ___ / ___ ___

☐ **Get a bill each month and pay by mail.**

6 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 for confirmation. Without a doctor's note, we may need to contact you to obtain additional information.

2. **Will you have other insurance coverage or prescription-drug coverage in addition to your Generations Advantage plan?** ☐ **Yes** ☐ **No**

   Some individuals may have other drug coverage, including other private insurance, TRICARE for Life, federal employee health-benefits coverage, VA benefits, state pharmaceutical-assistance programs, or employer/union group coverage.

   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

   Do you or your spouse work? ☐ **Yes** ☐ **No**

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 Facility: _____

   Address of Facility (number and street): _____

   Phone Number of Facility: _____

4. **Are you enrolled in a state Medicaid program?** ☐ **Yes** ☐ **No**
   If "yes," please provide your Medicaid number: _____

! Please Read This Important Information

If you currently have health coverage from an employer or union, joining Martin's Point Generations Advantage could affect your employer or union health benefits. *You could lose your employer or union health coverage if you join Martin's Point Generations 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 contact information, your benefits administrator or the office that answers questions about your coverage can help.

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7 Please Read and Sign

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

Martin's Point Generations 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 any other Medicare health plan or Medicare prescription drug plan. It is my responsibility to inform Generations Advantage of any prescription drug plan 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.

Martin's Point Generations Advantage serves a specific service area. If I move out of the area that Generations Advantage serves, I need to notify Generations Advantage so I can disenroll and find a new plan in my new area. Once I am a member of a Generations Advantage plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* from Martin's Point Generations Advantage 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 US border.

I understand that, beginning on the date my Generations Advantage coverage begins, only Medicare-covered services received from Generations Advantage Focus DC (HMO SNP) network providers will be covered, (except for emergency or urgently needed services, or out-of-the-area dialysis, which are covered in-and out-of-network).

I understand that services authorized by Generations Advantage and other services contained in the *Evidence of Coverage* (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR GENERATIONS ADVANTAGE 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 Generations Advantage, he/she may be paid based on my enrollment in Generations Advantage.

Continued on next page.

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

Your 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/agent/broker (if assisted in enrollment):

_____

_____

Broker received date:

_____

Must be submitted to Martin's Point within 24 hours of this date

Requested effective date of coverage:

_____

☐ ICEP/IEP ☐ AEP ☐ OEP

☐ SEP (type): _____

☐ No in-person meeting conducted, SOA not required

Martin's Point Health Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-640-4423 (ATS : 711). ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-640-4423 (TTY: 711).

White Copy: Return to Martin's Point
Yellow Copy: Keep for your records