



**MARTIN'S POINT**<sup>®</sup>

MEDICARE ADVANTAGE PLANS

GENERATIONS ADVANTAGE

# Individual Enrollment Form

## 2020 Prime (HMO-POS), Select (LPPO), Flex (RPPO), Value Plus (HMO), and Value (HMO) Plans

**There are four ways to enroll in a Martin's Point Generations Advantage plan:**

- 1. By mail:** Fill out this application, keep the yellow copy for your records, and mail the white copy in the enclosed envelope to:  
  
Martin's Point Generations Advantage  
891 Washington Avenue  
PO Box 9746  
Portland, ME 04104
- 2. By phone:** Call us at **1-888-408-8285 (TTY: 711)**. 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.
- 3. In person:** Call us at the number above to join us at an upcoming seminar or to schedule a one-on-one appointment with one of our representatives.
- 4. Online:** Visit **[MartinsPoint.org/GetStarted](https://MartinsPoint.org/GetStarted)** and complete an online application.

**Be sure to complete the entire enrollment form. Missing or incorrect information will delay enrollment processing.**

**1 To Enroll in a Martin's Point Generations Advantage Plan, Please Provide the Following Information**

**Please check which plan you would like to enroll in:**

- |                          |   |                        |
|--------------------------|---|------------------------|
| <input type="checkbox"/> | <b>PRIME (HMO-POS)</b> <i>Includes prescription drug coverage</i>   | <b>Monthly Premium</b> |
|                          | ME: Cumberland and York Counties  | \$0 per month          |
|                          | ME: Androscoggin, Kennebec, and Sagadahoc Counties  | \$29 per month         |
|                          | ME: Aroostook, Franklin, Hancock, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Somerset, Waldo, and Washington Counties | \$89 per month         |
|                          | NH: Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan Counties                                       | \$29 per month         |
|                          | NH: Belknap, Carroll, Coos, and Grafton Counties  | \$89 per month         |
| <input type="checkbox"/> | <b>SELECT (LPPO)</b> <i>Includes prescription drug coverage</i>   | <b>Monthly Premium</b> |
|                          | ME and NH: All counties   | \$99 per month         |
| <input type="checkbox"/> | <b>FLEX (RPPO)</b> <i>Includes prescription drug coverage</i>   | <b>Monthly Premium</b> |
|                          | ME and NH: All counties   | \$19 per month         |
| <input type="checkbox"/> | <b>VALUE PLUS (HMO)</b> <i>Includes prescription drug coverage</i>  | <b>Monthly Premium</b> |
|                          | ME: Androscoggin, Kennebec, Sagadahoc, and York Counties  | \$0 per month          |
|                          | ME: Aroostook, Franklin, Hancock, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Somerset, Waldo, and Washington Counties | \$29 per month         |
|                          | NH: Hillsborough and Strafford Counties   | \$0 per month          |
| <input type="checkbox"/> | <b>VALUE (HMO)</b> <i>NO prescription drug coverage</i>   | <b>Monthly Premium</b> |
|                          | ME and NH: All counties   | \$0 per month          |

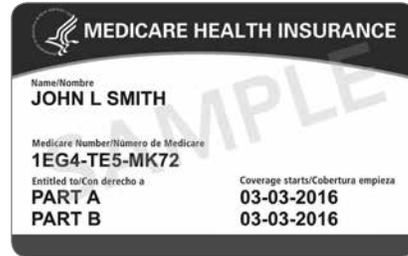
First Name:		Last Name:		Middle Initial:
Birth Date:	Sex:	Primary Phone Number: (    )		
(MM) (DD) (Y Y Y Y)	<input type="checkbox"/> M <input type="checkbox"/> F	Alternate Phone Number: (    )		
	<input type="checkbox"/> Unspecified	Email Address*:		
Permanent Residence Street Address (PO Box is not 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)

**Prime (HMO-POS), Value Plus (HMO), and Value (HMO) Plans Only:** Your Primary Care Provider (PCP) must be in the Martin's Point Generations Advantage network. If your current PCP is not in our network, you may choose a new in-network PCP or we will designate an in-network PCP for you. A list of in-network PCPs is available online at [MartinsPoint.org/Medicare](http://MartinsPoint.org/Medicare) or by calling Martin's Point Generations Advantage at 1-888-408-8285 (TTY: 711).

**Select (LPPO) and Flex (RPPO) Plans Only:** Plan members are not required to choose a PCP.

**Please provide your Generation's Advantage in-network PCP information below:**

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** (\_\_\_\_) \_\_\_\_\_

Is this your current physician?  Yes  No

Please designate a 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.

**\$0 Prime (HMO-POS) and \$0 Value Plus (HMO) Plans Only:** 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.

**Prime (HMO-POS), Select (LPPO), Flex (RPPO), and Value Plus (HMO) Plans with a Premium Amount:** You can pay your monthly plan premium (including any Medicare Part D late enrollment penalty that you currently have or may owe) by Electronic Funds Transfer (EFT), credit card, or mail each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

**All Prime (HMO-POS), Select (LPPO), Flex (RPPO), and Value Plus (HMO) Plans:** 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 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 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 including monthly prescription drug premiums, and coinsurance. 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](http://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 by mail.

**Please select a premium 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.**

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## 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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## 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 you 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 the plan so I can disenroll and find a new plan in my new area. Once I am a member of Generations Advantage, 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.

**Value (HMO) Plan Only:** I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a Part D late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

**Value (HMO) and Value Plus (HMO) Plans:** I understand that, beginning on the date Generations Advantage coverage begins, only Medicare-covered services received from Generations Advantage 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).

**Prime (HMO-POS), Select (LPPO), and Flex (RPPO) Plans:** I understand that beginning on the date Generations Advantage coverage begins, using in-network services can cost less than using out-of-network services, (except for emergency or urgently needed services or out-of-area dialysis services). If medically necessary, Generations Advantage Select (LPPO) and Flex (RPPO) provide refunds for all covered benefits, even if I get services out of network. 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 Generations Advantage will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Generations Advantage will release my information including my prescription-drug-event data (Prime, Flex, Select, and Value Plus plans only) 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: _____
<b>If you are the authorized representative, you must sign above and provide the following information:</b>	
Name: _____	
Address: _____	
Phone Number: (_____) _____	
Relationship to Enrollee: _____	

<b>Office Use Only:</b>	
Name of staff member(s)/agent/broker (if assisted in enrollment): _____ _____	Requested effective date of coverage: _____ <input type="checkbox"/> ICEP/IEP <input type="checkbox"/> AEP <input type="checkbox"/> OEP <input type="checkbox"/> SEP (type): _____ <input type="checkbox"/> No in-person meeting conducted, SOA not required
Broker received date: _____	
Must be submitted to Martin's Point within 24 hours of this date	

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