



810 South Main • Rugby, ND 58368 • 701-776-5848 1-800-525-5661

SUBSCRIBER NUMBER			
GROUP NUMBER		CONTRACT TYPE	

Medicare Cost Plan Enrollment Form

TO ENROLL IN HEART OF AMERICA HEALTH PLAN (HAHP), PLEASE PROVIDE THE FOLLOWING INFORMATION:

Please indicate your requested enrollment effective date: _____

LAST Name:	FIRST Name:	MIDDLE Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date: (<u> </u> / <u> </u> / <u> </u>) (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ()	
Permanent Residence Street Address:			
City:	State:	Zip Code:	
Mailing Address (only if different from your Permanent Residence Address):			
Street Address:	City:	State:	Zip Code
Emergency Contact [optional field]: _____			
Phone Number [optional field]: _____		Relationship to You [optional field]: _____	
E-mail Address [optional field]:			

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 the Railroad Retirement Board.

You must have Medicare Part B to join a Medicare Cost Plan.

 <small>SAMPLE ONLY</small>	
Name: _____	Sex: _____
Medicare Claim Number _____	
Is Entitled To	Effective Date
HOSPITAL (Part A) _____	
MEDICAL (Part B) _____	

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 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.

2. Do you or your spouse work? YES NO

Do you have health coverage through you or your spouse's current or former employer?..... YES NO

If "yes", please provide the following information:

Employer Name: _____ Employer Address: _____

Policy Holder Name: _____ Policy Number: _____

3. Are you enrolled in your State Medicaid program?..... YES NO

If "yes", please provide your Medicaid number: _____

[Optional field] **Please check one of the boxes below if you would prefer us to send you information in a language other than English:**

_____ Language A (e.g., Spanish)

Please choose your primary care location: _____

Your Plan Premium Payment Options:

Please select a premium payment option:

Receive a quarterly bill Receive a semi-annual bill Receive an annual bill

Electronic funds transfer from your bank account each month (you will need to attach a deposit slip from your account)

Please Read and Sign Below:

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

Heart of America Health Plan (HAHP) is a Medicare health *plan* and I will need to keep my Medicare Part B. I can be in only one Medicare Health plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I know I may disenroll from this plan at any time by sending a written request to HAHP or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

HAHP serves a specific service area. If I move out of the area that HAHP 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 HAHP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from HAHP when I receive it to know which rules I must follow in order to receive coverage with this Medicare health plan.

I understand that beginning on the date HAHP coverage starts, in order for HAHP to fully cover my medical services (except for emergency or urgently-needed services), all of my health care must be provided or arranged by HAHP. If I obtain services not provided or arranged by the plan, I will be responsible for all Medicare deductibles and coinsurance, as well as any additional charges as prescribed by the Medicare program. I may also be liable for charges not covered by Medicare.

Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico. Services authorized by HAHP and other services contained in my HAHP Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered.

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

