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

To Enroll in Capital Health Plan Retiree Advantage (HMO) in 2020, Please Provide the Following Information:

Capital Health PLAN℠
An Independent Licensee of the Blue Cross and Blue Shield Association

Name of Employer your Retirement Benefits are with:			**Group #:**
State of Florida Members Only: Please choose your plan: ☐ Retiree Advantage ☐ Retiree Classic			
Member Name (Last, First MI:			☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date:	**Sex:**	Home Phone Number: ( )	
/ /	☐ M ☐ F	Alternate Phone Number: ( )	
Permanent Residence (PO Box is not allowed):		Street:	
City:		State:	ZIP Code:	County:
Mailing Address (If different from your permanent residence):		Street:	
City:		State:	ZIP Code:	County:
Applicant's E-mail Address (Optional):			

Emergency Contact Information:	**Name**	**Relationship**	**Phone Number**

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue 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 (as it appears on your Medicare card)**:**

_____

Medicare Number:_____

Is Entitled To: **Effective Date:**

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Parts A and B, and be eligible for Part D to join a Medicare Advantage Prescription Drug plan.

Please Read And Answer These Important Questions

1. Are you the policyholder? □ Yes □ No

If Yes, retirement date? (mm/dd/yyyy): _____ Last date covered as active employee: _____

Are you covering a spouse or dependents under this employer plan?

☐ Yes ☐ No Name of spouse, if applicable: _____

Name of dependents, if applicable: _____

If you are **not** the policyholder, what is the policyholder's name? _____

Policyholder's retirement date (mm/dd/yyyy): _____ Last date covered as active employee: _____

2. Do you or your spouse work? □ Yes □ No

3. 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 showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

4. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, 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:
_____	_____	_____

5. 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):_____

6. Do you receive Medicaid benefits? □ Yes □ No

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

7. Please choose a primary care physician. _____

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

If you would prefer us to send you information in a language other than English or in another format, please contact our Member Services department at 850-523-7441 or 1-877-247-6512 (TTY 850-383-3534 or 1-877-870-8943) 8:00 a.m. – 8:00 p.m., seven days a week, October 1 – March 31; 8:00 a.m. – 8:00 p.m., Monday – Friday, April 1 – September 30. State of Florida members call 1-877-392-1532, 7:00 a.m. – 7:00 p.m.

Please Read And Sign Below

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

Capital Health Plan Retiree Advantage (HMO) 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 only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare Advantage health 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 if an enrollment period is available (Example: Annual Enrollment Period from October 15th – December 7th, or under certain special circumstances.)

Capital Health Plan Retiree Advantage serves a specific service area. If I move out of the area that Capital Health Plan Retiree 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 Capital Health Plan Retiree Advantage, 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 Retiree Advantage when I get it to know which rules I must follow in order 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 U.S. border.

I understand that beginning on the date Capital Health Plan Retiree 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 Retiree Advantage 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 the Medicare 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 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.

Signature:	**Today's Date:**

If you are the Legal Representative for the beneficiary, you must sign your name above and provide the following information:

Name: _____

Address: _____ **Phone Number**: (___) ____- _____

Relationship to Enrollee:_____

Please Read And Answer These Important Questions:

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 (insert date) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly enrolled in Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert 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 (insert 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 (insert date) _____.
- ☐ I recently left a PACE program on (insert date) _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ☐ I/my spouse have retired and my active coverage under my employer will end on (insert date) _____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ 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.

If none of these statements apply to you or you're not sure, please contact Capital Health Plan to see if you are eligible to enroll. We can be reached at 850-523-7441 or 1-877-247-6512 (TTY 850-383-3534 or 1-877-870-8943) 8:00 a.m. – 8:00 p.m., seven days a week, October 1 – March 31; 8:00 a.m. – 8:00 p.m., Monday – Friday, April 1 – September 30. State of Florida members call 1-877-392-1532, 7:00 a.m. – 7:00 p.m.

Capital Health Plan Retiree Advantage is an HMO plan with a Medicare contract.
Enrollment in Capital Health Plan Retiree Advantage depends on contract renewal.

Office Use Only:

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

Date Application Accepted (if assisted in enrollment):_____

Effective Date of Coverage: _____

Election Type:

IEP(E):_____ IEP 2(F):_____ ICEP(I):_____ MA OEP(O):_____ Dual/LIS Loss SEP(U):_____
Dual/LIS QTR SEP(L):_____ Perm Chg in Res(V):_____ EGHP SEP(W):_____
Other SEP(S):_____ AEP(A):_____ OEPI(T): _____

Date Application Considered Complete (if Incomplete at the time of receipt):

Date Application received by Capital Health Plan Enrollment Department:	**Processed in System:**
	Submitted to CMS: