MassHealth Senior care Options (SCO) & Medicare Advantage Enrollment Form

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

MassHealth Information

Are you enrolled in MassHealth? ☐ **Yes** ☐ **No**

Please write in your MassHealth ID number or attach a copy of your MassHealth card. Your MassHealth number is the 12-digit number under your name. MassHealth ID number: _____

You must be 65 years of age or older and have MassHealth Standard benefits to enroll in a senior care organization. To apply for MassHealth, call 1-800-841-2900 (TTY 1-800-497-4648 for people who are deaf, hard of hearing or speech disabled).

Do you have end-stage renal disease (ESRD)? ESRD is permanent kidney failure. ☐ 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.

Generally, if you answered yes to this question, you cannot enroll in a SCO plan.

Plan benefit package you want to enroll in (choose one below:)

☐ Senior Whole Health, LLC/001 ☐ Senior Whole Health, NHC/003 ☐ MH only (Non-Dual) ☐ SNF 001

To enroll in Senior Whole Health, please provide the following information.

Last name	First name	MI	Mr. ☐ Mrs. ☐ Ms. ☐
Date of birth	Sex ☐ Male ☐ Female		Home phone number
Written language preferred	Spoken language preferred		

Permanent resident street address (PO Boxes not allowed)

Street	City
State	Zip Code

Mailing address (only if different from your Permanent residence address):

Street	City
State	Zip Code

Medicare 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 care or your letter from the Social Security Administration or Railroad Retirement Board.

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

Name (as it appears on Medicare card):

_____

Medicare number:

_____

Is entitled to: Effective date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Please read and answer these important questions:

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

   Will you have other prescription drug coverage in addition to Senior Whole Health?

   ☐ Yes ☐ No

   If you answered "yes," please list other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage _____ ID # for other coverage _____ Group # for other coverage _____

2. 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 nursing facility		
Street address	City	
State	ZIP Code	Phone Number

3. Do you or your spouse work? ☐ Yes ☐ No
4. Please choose the name of a Primary Care Provider (PCP), clinic or health center:

   _____

5. Please check on of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

   ☐ Chinese ☐ Haitian Creole ☐ Khmer ☐ Portuguese ☐ Spanish ☐ Vietnamese

   ☐ Braille ☐ Large print ☐ Audio Tape

   Please contact Member Services at 1-888-794-7268 (TTY 711) from 8 a.m. to 8 p.m., 7 days a week if you need information in an accessible format or language other than what is listed above.

Please read this important information

If you currently have health coverage from an employer or union, joining Senior Whole Health could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Senior Whole Health. 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 information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read and sign on next page

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

Senior Whole Health is a Medicare Advantage plan and has a contract with the federal government and a contract with the Commonwealth of Massachusetts/MassHealth. I will need to keep my MassHealth Standard and my Medicare Parts A and B if I am eligible. 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 another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.

Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available or under other certain special circumstances. There is a Special Election Period (SEP) for individuals who have both Medicare Parts A and B and receive any type of assistance from Medicaid. The SEP allows me to enroll in, or disenroll from a plan once per quarter during the first nine months of the calendar year. That means, the SEP can be used one time during each of the following time periods (please see exceptions on page 5):

- January – March
- April – June
- July – September

When I make a request using the SEP, my enrollment status is effective the first day of the month following receipt of the request. From October 15 to December 7, I may also join, switch or drop a Medicare health or drug plan for an effective date of January 1 of the following year.

Because I have MassHealth and not Medicare Part A and/or Part B, I may leave Senior Whole Health at any time. I will no longer be covered by Senior Whole Health on the first day of the month following the month I request to leave Senior Whole Health. (Example: I request to leave this plan on July 10; I am no longer covered by this plan on August 1.)

Senior Whole Health serves a specific service area. If I move out of the area Senior Whole Health 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 Senior Whole Health, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Senior Whole Health when I get it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered Under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Senior Whole Health coverage begins, I must get all my health care from Senior Whole Health with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Senior Whole Health and other services contained in my Senior Whole Health Evidence of Coverage (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR Senior Whole Health 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 Senior Whole Health, he or she may be paid based on my enrollment in Senior Whole Health.

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 Senior Whole Health will release my information to Medicare, who may release it for research and other purposes that 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 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: 1) This person is authorized under state law to complete this enrollment and 2) Documentation of this authority is available upon request by Senior Whole Health or by Medicare.

Signature: _____

Print name: _____

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: _____

One of our Enrollee Service Representatives will be calling you within the next 10 days to verify the information on this form and to make sure you understand our plan rules.

Please provide a telephone number we may use for that call: _____

Best time to call: ☐ Morning ☐ Afternoon ☐ Evening

There are exceptions that may allow me to enroll in a Medicare Advantage plan outside of the SEP.

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 am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ 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 was released from incarceration. I was released on (insert date) _____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.

☐ 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 (insert date) _____.

☐ 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 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 am leaving employer or union coverage 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 enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

☐ 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 (insert date) _____.

☐ 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 applies to you or you're not sure, please contact Member Services at 1-888-794-7268 (TTY 711) from 8 a.m. to 8 p.m., 7 days a week.

Office Use Only

Name of staff member/broker agent (if assisted in enrollment)

_____

Plan ID No: _____ Effective date of coverage _____

NOTES: