

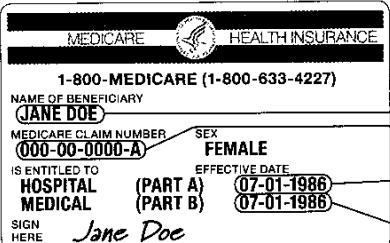
Individual Enrollment Request Form

1. Applicant Information (Please type or print in black or blue ink.)

Last Name		First Name		Middle Initial
Birth Date ____/____/____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Home Telephone Number ()		Work/Cell Telephone Number (optional) ()		
Permanent Residence Street Address (not a PO Box)				
City	State	ZIP Code	County	
Alternate Mailing Address (only if different from your Permanent Residence Street Address)				
City		State	ZIP Code	
E-mail Address (optional)				

2. Medicare Information

Please take out your red, white and blue Medicare card to complete this section — OR — Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

 <p>MEDICARE HEALTH INSURANCE 1-800-MEDICARE (1-800-633-4227) NAME OF BENEFICIARY JANE DOE MEDICARE CLAIM NUMBER (000-00-0000-A) SEX FEMALE IS ENTITLED TO HOSPITAL (PART A) EFFECTIVE DATE MEDICAL (PART B) (07-01-1986) SIGN HERE <i>Jane Doe</i></p>	Beneficiary's Name (exactly as it appears)	_____
	Medicare Claim Number	_____ Letter(s)
	Part A (Hospital) effective date	____/____/____
	Part B (Medical) effective date	____/____/____

→ **You must have Medicare Part A and Part B to join a Medicare Advantage plan such as SecureHorizons® MedicareDirect.™**

3. Your Payment Options (If applicable)

If you have a plan premium AND/OR we determine that you owe a late-enrollment penalty, the amount can be automatically deducted from your Social Security benefit check. The automatic deduction from your monthly Social Security benefit check may take two or more months to begin. In most cases, the first deduction will include all premiums due from your enrollment effective date up to the point withholding begins. If you don't choose this option, we will provide you a coupon book or you can sign up for Electronic Funds Transfer (EFT). Generally, you must stay with the option you choose for the rest of the year. People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late-enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this 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 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, it is recommended you choose the coupon book or EFT option. Unless checked otherwise, you will receive a coupon book for the amount that Medicare doesn't cover. If you would like to set up EFT, please enclose a blank check with VOID written on the front.

If there is a plan premium, and/or a late-enrollment penalty, deduct the total amount from my:
(Choose only ONE payment method. You must initial your selection. If nothing is checked, you will receive a coupon book.)

- Monthly Social Security benefit check** _____ (Initials) **Coupon Book** _____ (Initials)
- Electronic Funds Transfer (EFT)** from your bank account each month. _____ (Initials) Enclose a **VOIDED** check OR provide the following:
 Account Holder Name _____ Bank Routing Number _____
 Bank Account Number _____ Account Type: Checking Savings

4a. Benefit Plan Selections — Choose Only One:

- Private Fee-For-Service (PFFS) plans with a medical and Part D drug benefit:
- SecureHorizons® MedicareDirect™ RX Plan 51 (PFFS)
 - SecureHorizons® MedicareDirect™ RX Plan 53 (PFFS)
 - SecureHorizons® MedicareDirect™ RX Plan 55 (PFFS)
 - SecureHorizons® MedicareDirect™ RX Plan 56 (PFFS)
 - SecureHorizons® MedicareDirect™ RX Plan 58 (PFFS)
 - SecureHorizons® MedicareDirect™ RX Plan 59 (PFFS)
 - SecureHorizons® MedicareDirect™ RX Plan 60 (PFFS)
 - SecureHorizons® MedicareDirect™ RX Plan 150 (PFFS)
- PFFS plans with medical benefits only:
- SecureHorizons® MedicareDirect™ Plan 1 (PFFS)
 - SecureHorizons® MedicareDirect™ Plan 2 (PFFS)
 - SecureHorizons® MedicareDirect™ Plan 3 (PFFS)
 - SecureHorizons® MedicareDirect™ Plan 100 (PFFS)

4b. Contract Information — Refer to Cover of Summary of Benefits

Contract/H # _____ PBP/Plan# _____

5. Please Read and Answer These Important Questions

Do you have End-Stage Renal Disease (ESRD)? Yes No
 If you answered yes and you don't need regular dialysis any more, or if you have had a successful kidney transplant, please attach a note or records from your physician showing you don't need dialysis or have had a successful kidney transplant. (Use Form 2728 if available.)
 If yes, are you currently a member of a health care company? Yes No
 If yes, name of company _____ I.D. # _____

Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)? Yes No

If yes, name of institution _____
 Address of institution _____ City, State _____
 Telephone number of institution (_____) _____ Your date of admission to the institution ____/____/____

Are you enrolled in your state Medicaid program? Yes No

If yes, please provide your Medicaid number _____

Do you or your spouse work? Yes No

Do you or your spouse have any health insurance other than Medicare, such as private insurance, Workers' Compensation, or Veterans Administration (VA) benefits? Yes No

If you have other health insurance, what kind do you have? _____
 What is the name of the health insurance? _____
 Group# _____ I.D. # _____

Do you have any other prescription drug coverage such as private insurance, TRICARE, VA benefits, State Pharmaceutical Assistance Program or Federal Employee Health Benefits coverage? Yes No

Plan name of other coverage _____
 I.D. # for this coverage _____

6. Provider Contact Information

Before you seek covered services, we would like to provide your physician and hospital with information about the SecureHorizons® MedicareDirect™ plan.

This request for information is completely voluntary and will not impact your enrollment in the plan. Providing this information will:

- Help your physician and hospital understand your SecureHorizons® MedicareDirect™ Private Fee-For-Service plan coverage.
- Help ensure your claims are processed more smoothly because your providers have the information and addresses required for payment.

Please provide us with the names and phone numbers of the physicians and hospital that you currently use or might use in the future in the area below. If you don't have a doctor/hospital, or cannot provide the requested information, please write "not available" in the spaces below.

Physicians I currently use or might use in the future:

Physician Name _____ Phone (_____) _____ City/State _____

Physician Name _____ Phone (_____) _____ City/State _____

Hospital to contact:

Hospital Name _____ Phone (_____) _____ City/State _____

Note: This list does not limit you to seeing only those providers listed. You may use any Medicare eligible physician and Medicare certified hospital or health care provider who agrees to accept the SecureHorizons® MedicareDirect™ plan's terms and conditions of payment.

7. Please Read This Important Information

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 enrollment request form means that I have read, understand and agree to the contents of this enrollment request form. Statements of Understanding and the Additional Statement of Understanding (for the plan I have chosen) on the back of this form.

You must sign and date this Individual Enrollment Request Form in order for it to be processed.

If signed by an authorized representative of the applicant, this signature certifies the person is authorized under state law to complete this enrollment request form and make health care decisions on behalf of the applicant and is authorized to receive health care related information on his/her behalf and that documentation of this authority is available upon request by the plan or by CMS. I will notify the plan if the authority to receive health care related information changes.

Signature of applicant/member/authorized representative	Date ____/____/____
---	------------------------

Signature of individual who assisted in completing this request form and/or witness	Date ____/____/____
---	------------------------

Relationship to applicant (*if you assisted in completing this request form*)

If you are the authorized representative of the applicant, you must provide the following information and sign above.

Name		Relationship to applicant	
Address		Telephone Number { }	
City	State	ZIP Code	Work/Cell Telephone Number { }

8. Alternative Formats

If available, I prefer to receive materials in the following format: Spanish Chinese Large Print

Please contact SecureHorizons® at 1-800-555-5757 if you need information in another format or language than those listed above. Our office hours are 8 a.m. – 8 p.m. local time, 7 days a week. TTY users should call 711.

9. For Sales Representative/Agency Use Only

Selling Staff Member/Agent I.D. DW4758	Initial Receipt Date	Election Period:	
Selling Staff Member/Agent Name Kendall Erickson	Proposed Effective Date	<input type="checkbox"/> AEP	<input type="checkbox"/> ICEP
Agency wyohealth.com	Agent Telephone Number 866-944-9991	<input type="checkbox"/> IEP	<input type="checkbox"/> OEPI
Signature Kendall Erickson		<input type="checkbox"/> OEPNEW	<input type="checkbox"/> OEP
		<input type="checkbox"/> SEP _____ (SEP Reason Code)	

Statements of Understanding**By Completing This Enrollment Request Form, I Agree to the Following:**

- SecureHorizons® MedicareDirect™ is a Medicare Advantage Plan and has a contract with the Federal Government. I must keep my Medicare Parts A and B by continuing to pay the Part B premiums and, if applicable, Part A premiums, if not otherwise paid for under Medicaid or by another third party. I can only be in one Medicare Advantage plan or Medicare Advantage Prescription Drug plan at a time. By enrolling in this plan, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS), from any other Medicare Advantage plan of which I may be a member. If I enroll in a Medicare Advantage (MA) Plan that does not include Medicare prescription drug coverage, I may enroll in a Medicare Prescription Drug Stand-alone Plan and will not be automatically disenrolled from the Medicare Advantage-only plan. It is my responsibility to inform the plan of any prescription drug coverage that I have or may get in the future. For MA-only plans: 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 late-enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year, unless special election periods apply. 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: November 15-December 31 of every year), by sending a request to the plan or by calling 1-800-MEDICARE (1-800-633-4227); (hearing impaired users should call 1-877-486-2048), 24 hours a day, 7 days a week.
- I understand that I must live in the service area and if I move out of the service area, I must notify the plan of the move. I understand that if I permanently move out of the service area, CMS requires that the plan disenroll me. 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 as a member of this plan, I have the right to appeal plan decisions about payments or services if I disagree. I understand that I will be bound by the benefits, copayments, exclusions, limitations and other terms of the plan. It is my responsibility to read the Evidence of Coverage when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage plan and the amounts for which I will be responsible for payment under the plan.

