



Medicare Advantage Enrollment Application



Vantage Health Plan, Inc.
 130 Desiard Street, Suite 300
 Monroe, LA 71201
 (318) 361-0900 TTY (318) 361-2131
 (888) 823-1910 TTY (866) 524-5144

To enroll in Vantage Medicare Advantage, please provide the following information

Please check the **Vantage HMO-POS** plan you want to enroll in:

_____ AAA0 Vantage **Zero \$0.00** per month _____ AAA4 Vantage **Traditional Plus \$31.30** per month

_____ AAA3 Vantage **Premium \$99.00** per month _____ AAA5 Vantage **Dual SNP \$31.30** per month

Last Name	First Name	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date: ____ / ____ / ____ <small>Month Day Year</small>	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number: ____ - ____ - ____ <small>(providing this information is optional)</small>	Home Phone Number: (____) ____ - ____
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Permanent Residence Street Address (*P.O. Box is not allowed*):

City:	State: Parish:	ZIP Code:
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Mailing Address (*only if different from your Permanent Residence Address*):

Street:	City:	State:	ZIP Code:
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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 A and Part B to join a Medicare Advantage plan.

 <p style="text-align: center;">SAMPLE CARD ONLY</p>	
Name: _____	
Medicare Claim Number	Sex _____
_____ - _____ - _____	
Is Entitled to	Effective Date
HOSPITAL (Part A)	_____ - _____ - _____
MEDICAL (Part B)	_____ - _____ - _____

Paying Your Plan Premium

You can pay your monthly plan premium by mail, electronic funds transfer or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security check each month.

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, we will bill you for the amount that Medicare does not cover.

If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

- Receive a bill each month.
- Electronic funds transfer (EFT) from your bank account each month. Please enclose a *VOIDED* check.

Account holder name: _____

Bank routing number: _____

Bank account number: _____

Account type: Checking Saving

- Credit Card. Please provide the following information:

Type of Credit Card: _____

Name of Account holder as it appears on card: _____

Account number: ____ - ____ - ____ - ____

Expiration Date: ____ / ____

Month Year

- Automatic deduction from your monthly SSA benefit check. The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.

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 if you 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. 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 Vantage Health Plan? Yes No

If "yes" please list your other coverage and your identification (ID) number(s) for the other coverage:

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

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: _____

Phone number for facility: _____

4. Are you enrolled in your State Medicaid program? Yes No

If yes, please provide your Medicaid number: _____

5. Do you or your spouse work? Yes No

Please choose and enter the name of a Primary Care Physician (PCP):

Please contact Vantage Medicare Advantage at (888) 823-1910 if you need information in another format or language, Monday through Friday from 8:00 AM – 8:00 PM. TTY users should call (866) 524-5144.



Please Read This Important Information

If you currently have health coverage from an employer or union, joining Vantage Health Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Vantage Medicare Advantage. Read the communications your employer or union sends you. If you have any questions, visit their website or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

PLEASE READ AND SIGN THE NEXT PAGE

Please read and Sign Below

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

Vantage Medicare 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 understand that I will continue to pay my Part B premium. I can only be in one Medicare Advantage plan at a time, and 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. Enrollment in this plan is generally for the entire year. 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), or under certain special circumstances.

Vantage Medicare Advantage serves a specific service area. If I move out of the area that Vantage Medicare 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 Vantage Medicare Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Vantage Medicare Advantage when I receive it to know which rules I must follow in order to receive coverage with the Vantage 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 Vantage Medicare Advantage coverage begins, I must get all of my health care coverage through Vantage Medicare Advantage with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Vantage and other services contained in my Vantage Medicare Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **WITHOUT AUTHORIZATION, NEITHER MEDICARE NOR VANTAGE MEDICARE ADVANTAGE WILL PAY FOR THE SERVICES.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual contracted with Vantage Medicare Advantage, he/she may be compensated based on my enrollment this plan.

Release of Information:

By joining this Medicare Advantage health plan, I acknowledge that Vantage Medicare Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and operations. I also acknowledge that Vantage Medicare Advantage 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 on this application (or the signature of the person authorized to act on behalf of the individual under the laws of the State where I live) 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 by Vantage Medicare Advantage or by Medicare.

Your Signature: _____

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: _____

Office Use Only:

Name of staff member (if assisted in enrollment): _____

Effective Date of Coverage: _____

ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____

Please add Broker Name _____ and # _____