



VANTAGE HEALTH PLAN, INC.  
*Making Healthcare Work!*

## Medicare Advantage Enrollment Election Form



**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 plan you want to enroll in:

AAA0 Vantage Zero (HMO-POS) \$0.00 per month     
  AAA3 Vantage Premium (HMO-POS) \$99.00 per month  
 AAA1 Vantage Value (HMO-POS) \$49.00 per month     
  AAA4 Vantage Traditional Plus (HMO) \$35.00 per month

Last Name	First Name	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date: ____ / ____ / ____ <small>Month   Day   Year</small>	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: (____) ____ - ____	Alternate Phone Number: (____) ____ - ____
Permanent Residence Street Address ( <i>P.O. Box is not allowed</i> ):			
City:	Parish:	State:	ZIP Code:
<b>Mailing Address</b> ( <i>only if different from your Permanent Residence Address</i> ):			
Street:	City:	State:	ZIP Code:
<b>Emergency Contact:</b> _____			
<b>Phone Number:</b> _____		<b>Relationship to You:</b> _____	
<b>Email Address:</b> _____			

**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 Social Security or the Railroad Retirement Board.

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

<b>MEDICARE</b> <b>HEALTH INSURANCE</b>
<i>SAMPLE CARD ONLY</i>
Name: _____
Medicare Claim Number      Sex _____
_____ - _____ - _____
Is Entitled to      Effective Date
<b>HOSPITAL (Part A)</b> _____ - _____ - _____
<b>MEDICAL (Part B)</b> _____ - _____ - _____

## Paying Your Plan Premium

**AAA0 Vantage Zero Plan Only:** If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail, electronic funds transfer (EFT), or credit card each month, or by prepaying quarterly or annually. You can also choose to pay by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

**For all other Plans:** You can pay your monthly plan premium, including any late enrollment penalty that you currently have or may owe, by mail, electronic funds transfer (EFT) or credit card each month, or by prepaying quarterly or annually. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. **DO NOT** pay Vantage Medicare Advantage the Part D-IRMAA.

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](http://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:    Monthly    Quarterly (prepay only)    Annually (prepay only)
- 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 Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security or RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums. )

**Please read and answer these important questions:**

1. Do you have End Stage Renal Disease (ESRD)?  Yes  No

If you have had a successful kidney transplant and/or you do not need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you do not need dialysis; otherwise, we may need to contact you to obtain additional information.

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 Medicare Advantage?  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 Institution: \_\_\_\_\_

Address & Phone Number of Institution (number & street): \_\_\_\_\_

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 Medical Home Primary Care Physician (MH-PCP):**

Please check the box below if you would prefer us to send you information in another format:

Digital Documents (Online documents instead of paper documents)

Please contact Vantage Medicare Advantage at (888) 823-1910 if you need information in another format or language than what is listed above. Our office hours are 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 Medicare Advantage 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 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 can be in only 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. 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: October 15 – December 7 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 document from Vantage Medicare Advantage when I receive it to know which rules I must follow in order to get 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, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Vantage Medicare Advantage 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 getting assistance from a sales agent, broker, or other individual employed by or contracted with Vantage Medicare Advantage, he/she may be paid based on my enrollment in Vantage Medicare Advantage.

**Release of Information:** By joining this Medicare health plan, I acknowledge that Vantage Medicare Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare 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 (or the signature of the person authorized to act on behalf of the individual 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 authorized representative, you must sign above and provide the following:

Name: \_\_\_\_\_ Relationship to Enrollee: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Office Use Only:**

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

Broker Name \_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_

AEP: \_\_\_ ICEP/IEP\*: \_\_\_ SEP\*(type): \_\_\_\_\_ Meeting \_\_\_ Home Visit \_\_\_ Date(meeting/home visit): \_\_\_\_\_

**\*Must complete Attestation of Eligibility for all enrollments outside of AEP**