



ATRIO HEALTH PLANS ELECTION FORM

ATRIO Health Plans
 500 SE Cass, Suite 230 • Roseburg, OR 97470
 (541) 672-8620, (877) 672-8620 or TTY (800) 735-2900

To Enroll in ATRIO Health Plans, Please Provide the Following Information:
Please check which plan you want to enroll in:

Douglas and Klamath Counties only:

- ATRIO MyAdvantage Active (HMO)
- ATRIO MyAdvantage Active Rx (HMO)
- ATRIO MyAdvantage II (HMO)
- ATRIO MyAdvantage II Rx (HMO)
- ATRIO MyAdvantage Elite Rx (HMO-POS)
- ATRIO MyAdvantage Choice Rx (HMO-POS)
- ATRIO MyAdvantage Special Needs Plan (HMO)

Washington County only:

- ATRIO Tuality MyAdvantage Active (HMO)
- ATRIO Tuality MyAdvantage Active Rx (HMO)
- ATRIO Tuality MyAdvantage II (HMO)
- ATRIO Tuality MyAdvantage II Rx (HMO)
- ATRIO Tuality MyAdvantage Elite Rx (HMO-POS)
- ATRIO Tuality MyAdvantage Choice Rx (HMO-POS)
- ATRIO Tuality MyAdvantage Companion (HMO)

LAST name: _____ FIRST Name: _____ Middle Initial _____

Birth Date: ____/____/____ (MM/DD/YYYY) Sex: M F Home Phone Number: _____ Alternate Phone Number (Optional field): _____

Permanent Residence Street Address: _____

City: _____ State: _____ ZIP Code: _____

Mailing Address (only if different from your Permanent Residence Address):

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Emergency contact (Optional field): _____

Phone Number: _____ Relationship to You: _____

E-mail Address: (Optional field) _____

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.

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY _____

MEDICARE CLAIM NUMBER _____ SEX _____

IS ENTITLED TO _____ EFFECTIVE DATE _____

HOSPITAL MEDICAL (PART A) (PART A)

Paying Your Plan Premium

If we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail, Electronic Funds Transfer (EFT), each month or quarterly.

You can also choose to pay your premium by automatic deduction from your Social Security benefit 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% of 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 (options – monthly, quarterly, annually)

Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: _____

Bank account number: _____

Account type: Checking Saving

Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security 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 (MA plan)? 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 _____

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 (number and street): _____

Phone Number: _____

Please Read And Answer These Important Questions (continued)

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 the name of a Primary Care Physician (PCP), clinic or health center:

Do not currently have a PCP

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

Language _____

Braille Audio Tape Large Print

Please contact ATRIO Health Plans at (541) 672-8620, Toll Free (877) 672-8620. TTY users should call TTY number (800) 735-2900 if you need information in another format or language than what is listed above. Our office hours are Monday to Friday, 8am to 5pm

STOP - Please Read This Important Information - STOP

If you currently have health coverage from an employer or union, joining ATRIO Health Plans could affect your employer or union health benefits. You could lose your employer or union health coverage if you join ATRIO Health Plans. If you have health coverage from an employer or union, joining ATRIO Health Plans may change how your current coverage works. 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 & Sign Below

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

ATRIO Health Plans 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 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. ***(Only if choosing MyAdvantage Active or MyAdvantage II):*** I understand that if I do not 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. 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), or under certain special circumstances.

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

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with ATRIO Health Plans, he/she may be paid based on my enrollment in ATRIO Health Plans.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.

Please Read & Sign Below (continued)

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan ATRIO Health Plans will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that ATRIO Health Plans 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 by ATRIO Health Plans or by Medicare.

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/agent/broker (if assisted in enrollment): _____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____