

HEALTH NET ORANGE (PDP) SHORT ENROLLMENT FORM

Name of plan you are enrolling in: _____			
Name:		Medicare Number:	
Home Phone Number:			
Permanent Street Address:			
City:		State:	ZIP Code:
Mailing Address: (only if different from your Permanent Street Address)			
Street Address:		City:	State: ZIP Code:
<p>Please fill out the following: I am currently a member of the _____ plan in Health Net Orange with a monthly plan premium of \$_____. I would like to change to the _____ plan in Health Net Orange. I understand that this plan has different prescription benefits and a monthly premium of \$_____.</p>			
<p>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: <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Braille <input type="checkbox"/> Large Print</p> <p>Please contact Health Net Orange at 1-800-865-9431 if you need information in another format or language than what is listed above. Our office hours are 8:00 a.m. - 8:00 p.m., 7 days a week. TTY users should call 711.</p>			
Your Plan Premium			
<p>You can pay your monthly plan premium by mail or Automatic Bank Draft (ABD) each month. You can also choose to pay your premium by automatic deduction from your Social Security benefits check each month. People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, 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 won't have a coverage gap or a late enrollment penalty. Many people qualify 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.</p> <p>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 doesn't cover.</p> <p>If you don't select a payment option you will get a bill each month.</p>			
<p>Please select a premium payment option: <input type="checkbox"/> Get a bill <input type="checkbox"/> Automatic Bank Draft (ABD) <input type="checkbox"/> 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.)</p>			

White copy – Health Net

Yellow copy – Medicare Dept.

Pink copy – Member

PLEASE READ AND SIGN BELOW:

Health Net Orange is a Medicare prescription drug plan and has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Health Net Orange, he/she may be compensated based on my enrollment in Health Net Orange.

Release of Information: By joining this prescription drug plan, I acknowledge that the Prescription Drug Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Net Orange 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 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 Health Net Orange coverage begins, I must get all of my prescription drug services from Health Net Orange. Prescription drugs authorized by Health Net Orange and contained in my Health Net Orange Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH NET ORANGE WILL PAY FOR THE SERVICES.**

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 the individual resides) 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 Health Net Orange 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:** _____

Medicare Prescription Drug Plan use only:

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

Requested Effective Date of Coverage: _____

Effective Date of Coverage: _____ Plan/Group ID: _____ Plan Code: _____

PCP Code: _____ PPG Code: _____ Batch Number: _____

Application Date: _____ Health Net Member ID: _____

EFT/Voided Check Received: Yes No Initial Payment Check Received: Yes No Faxed In: Yes No

Election Period (check one): ICEP/IEP: OEP/New: OEPI: AEP: SEP (type): _____

Application Pended due to: _____

Producer Name: _____ Phone #: _____ ID #: _____

FMO/GA/Agency Name: _____ Phone #: _____ ID #: _____

Sales Rep Name: _____ Phone #: _____ ID #: _____

Producer Received Date: _____