How to Complete Your Medicare Advantage Prescription Drug Plan (MAPD) ENROLLMENT Form – With SAMPLE

Only for those enrolled in Medicare Part A and Part B

Follow the instructions below and refer to the attached sample to help you fill out and submit your MAPD enrollment form. Any missing information or documentation will cause a delay in your enrollment. The sample form provides detailed instructions for each of the different form sections.

How to Complete Your Form

Fill in **all** the required areas, referring to the sample form. All medical forms must be completed by the retiree, survivor, or guardian/conservator/attorney-in-fact.

You must have both Medicare Part A and Part B to join a Medicare Advantage plan. If you and your Medicare-eligible dependent are both enrolling, you must each complete a separate MAPD form.

You will need the following to fill out your form (as applicable):

- Social Security number and Medicare card
- The name and facility number of the contracting medical group or physician that you have selected. Refer to your plan's provider directory for medical group and physician information
- Dates of retirement, marriage/domestic partnership
- Name and ID number of any other drug coverage you will have (e.g., private insurance, worker's comp, VA, or state assistance program)
- Long-term care facility information, if applicable

If you have questions or need help with completing the form, call us at 800-786-6464.

How to Submit Your Form

Your completed form must be **physically signed** (even if you complete the fillable PDF form). No electronic signatures are accepted at this time.

Submit **all five pages of the form** and **all the required documentation.**

You will need to provide the following documentation with your form, (as applicable):

- A photocopy of your Medicare card
- For **spouses or partners:** photocopy of original marriage certificate or domestic partnership with the California Secretary of State
- **Photocopies of certificates must be accompanied by a signed attestation** certifying that the photocopy is a true and correct copy of the certificate and contains no alterations from the original
- If applicable, legal document establishing guardianship, conservatorship, or power of attorney

If someone assisted you in completing the form, they must sign and state their relationship to you at the bottom of Section 5, page 5. If your attorney-in-fact or other legal representative (as defined by state law) has helped you complete this form, they must sign and attach certificate or other written proof of guardianship.

Before submitting, ensure that you have:

- Signed and dated the arbitration agreement that applies to your plan in Section 3
- Signed and initialed, the authorization in Section 5

To submit your form and documentation:

- **Scan and upload** your forms to My LACERA via lacera.com (*recommended*). This is the fastest method of submission, and you will receive a confirmation of receipt. **OR**
- **Mail** your forms to LACERA, P.O. Box 7060 Pasadena, CA 91109-7060. **OR**
- **Fax** your forms to 626-564-6155. **OR**
- **Drop off** your forms in the secure drop-box outside our Member Service Center at 300 N. Lake, Pasadena, CA 91101.

Remember to keep a copy for your records.

LACERA treats your and your family's personal health information as confidential. We follow the applicable sections of HIPAA related to privacy and security of your protected health information. If you have any questions about the steps taken to secure your protected health information, please refer to the HIPAA policy posted on the LACERA website, www.lacera.com.

Los Angeles County Employees Retirement Association

Medicare Advantage Prescription Drug Plan (MAPD) Universal Enrollment/Election Form

1

(To Be Filled out by LACERA)
Retirement Date: ______________
Effective Date: ______________
☐ SCD ☐ NSCD ☐ Tier 1 ☐ Tier 2

Years of Service:
Current Med:
New Med:
Premium:

Email/Fax Date:
Input Date:
AME Entry Date:
Emp Site Entry Date:

PPA:
Initials:

2

Please check all that apply:
Completed by:
☐ Retiree Enter retirement date: ______________
☐ Spouse/DP Enter name of retiree: ______________
☐ Survivor Enter name of retiree: ______________

3

Marital Status:
☐ Single ☐ Married,
☐ Widowed If yes Date of Marriage/
☐ Divorced/ DP Registration
Termed DP ______________

1 *Do not complete the gray section.* (FOR LACERA USE ONLY)

2 Check **one** "Completed by" box and enter applicable information in the space provided.

3 Select your marital status and provide date if applicable. If you are married or part of a registered domestic partnership, select the "Married" box and fill in the date of marriage/ domestic partnership in the space provided.

Section 1

SECTION 1: Personal Information

Medicare Advantage Prescription Drug (MAPD) plan you are requesting enrollment in:

4

Employer Group Name **LACERA**	Group#	Requested Effective Date (subject to CMS approval)
Desired Contracting Medical Group (if applicable)	Desired Contracting Physician (if applicable)	Medical Group/Physician No. (if applicable)

Last Name: DOE | First Name: JANE | MI: A | Gender: ☐ M ☐ F

Permanent Residence Address (Street Address Only—No P.O. Box)
PERMANENT ADDRESS

City: PERMANENT ADDRESS | State: ADDRESS | Zip: ADDRESS | County:

Mailing Address if Different (Street, City, State, Zip)
MAILING ADDRESS

Daytime Phone Number (including area code)
(XXX) XXX-XXXX

E-mail address (optional)

Evening Phone Number (including area code)
(XXX) XXX-XXXX

Social Security Number (SSN)
XX-XX-XXXX

Date of Birth
XX/XX/XXXX

5

Are you the Subscriber? ☐ Yes ☐ No
If no, provide Subscriber Name and Social Security Number (your group may require this information)
Subscriber Name ______________ Subscriber SSN__ __ __-__ __-__ __ __ __

4 Enter the Medicare Advantage Prescription Drug (MAPD) plan you are requesting enrollment in and your personal information where highlighted, starting with last name/first name and gender. You do not need to complete the medical group and physician information until Section 4.

5 The subscriber is the retiree or the survivor.

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card. **Please provide a copy of retiree and/or dependent Medicare card**

OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card): 6

____

Medicare Number:____________________

Is Entitled To:	Effective Date
HOSPITAL (PartA)	----/----/--------
MEDICAL (Part B)	----/----/--------

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

6 Provide your Medicare information as appears on your Medicare card.
Recommended: Include a copy of the retiree's and/or dependent's Medicare card when you submit your MAPD form.

DOE	JANE	A	XXX-XX-XXXX
7 Last Name (Print)	First Name (Print)	M.I.	Social Security Number

7 Fill out name, and Social Security information on the top of page 2.

Section 2

SECTION 2: Medical Information

8

1. Are you the retiree? ☐ Yes ☐ No
   If yes, retirement date (month/date/year): _____ /_____ /_______
   If no, name of retiree: ________________________________

2. Are you covering a spouse or dependents under this employer plan? ☐ Yes ☐ No
   If yes, name of spouse: ________________________________
   Name(s) of dependent(s): ________________________________

3. Do you or your spouse work? ☐ Yes ☐ No

4. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or state pharmaceutical assistance programs. Will you have other prescription drug coverage? ☐ Yes ☐ No
   If yes, please list your other coverage and your identification(ID) number(s) for this coverage.
   Name of other coverage:________________________________
   ID # for coverage: ________________________________

5. 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 of Institution (number and street): ________________________________
   Phone Number of Institution:(______) ________ - __________

8 Answer questions 1 through 5 and provide any requested information.

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

9 This health plan 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 only be in 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. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. 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. I may leave this plan at any time by sending a request to the health plan or by calling **1-800-MEDICARE** (**1-800-633-4227** or **TTY 1-877-486-2048**), 24 hours a day, 7 days a week. However, before I request disenrollment, I will check with my group or union/trust fund to determine if I am able to continue my group membership.

I understand that if I currently have coverage through more than one employer or union/trust fund, I must choose one of these coverage options for my Medicare Advantage plan because I can be enrolled in only one Medicare Advantage plan at a time. My other employer or union/trust fund may allow me to enroll in one of their non-Medicare plans as well. I will contact the benefit administrators at each of my employers or trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or trust fund's plan to select for my Medicare Advantage plan.

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

RELEASE OF INFORMATION:

By joining this Medicare Health Plan, I acknowledge that the Medicare Health Plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that this Medicare Health Plan 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/election 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 from Medicare.

9 Carefully review the information on pages 2 and 3 to ensure you understand the requirements of your enrollment in the LACERA-administered MAPD plan.

10 DOE | JANE | A | XXX-XX-XXXX
Last Name (Print) First Name (Print) M.I. Social Security Number

10 Fill out name, and Social Security information on the top of page 3.

Section 3

Carefully review the arbitration agreement for your selected health care plan, and sign and date where indicated.

11

SECTION 3: Binding Arbitration Agreements

Arbitration Agreement for UnitedHealthcare (UHC), Cigna HealthCare and SCAN Health Plan

I understand that, if I select a health insurance plan ("health plan") that uses mandatory binding arbitration to resolve disputes, I am agreeing to arbitrate claims that relate to my or a dependent's membership in the health plan (except for Small Claims Court cases, claims governed by the ERISA claims regulation, and other claims that cannot be subject to binding arbitration under governing law). I understand that any dispute between myself, my heirs, relatives, or other associated parties on the one hand and the health plan, any contracted health care benefit providers, administrators, or other associated parties on the other hand for alleged violation of any duty arising out of or related to membership in the health plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is in the health plan's coverage document, which is available for my review.

Signature ______________________ **Date** __________

If you are the authorized representative, you must sign above and provide the following information:

Name ______________________
(Please print)

Address ______________________

Phone Number ( ) ________ - __________

Relationship to Enrollee ______________________

11 For **UnitedHealthcare (UHC), Cigna HealthCare, and SCAN Health Plan**, sign and date the arbitration agreement on page 3 of the form.

DOE JANE A XXX-XX-XXXX

12 Last Name (Print) | First Name (Print) | M.I. | Social Security Number

12 Fill out name, and Social Security information on the top of page 4.

13 **Arbitration Agreement for Kaiser Foundation Health Plan - California**

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP , including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Signed ____ Date ________________ 20________

13 For the Kaiser Health Plan-California, sign and date the first arbitration agreement at the top of page 4.

Arbitration Agreement for Kaiser Foundation Health Plan - Hawaii

14 **Except as provided in the Kaiser Foundation Health Plan Hawaii Arbitration Agreement, any and all claims or disputes shall be resolved by binding arbitration. I acknowledge that I have read and understood the information in the Kaiser Foundation Health Plan Hawaii Arbitration Agreement (attached). I, on behalf of myself, all applicants, and family members, hereby agree to binding arbitration and give up our constitutional rights to a jury or court trial.**

Signed ____ Date _______________ 20________

14 For the Kaiser Health Plan-Hawaii, sign and date the second arbitration agreement at the top of page 4.

Section 4

SECTION 4: Medical Plan

I wish to enroll in the following MAPD plan: (Check one and fill in the requested information. Refer to your plan's Provider Directory for physician/medical group selections.)

15

☐ **Kaiser Permanente Senior Advantage**
Please check the state in which you live: ☐ CA ☐ CO ☐ GA ☐ HI ☐ OR ☐ WA
If you were ever a Kaiser member when you were under age 65, please list your medical record number ______________________

☐ **Cigna Preferred Rx (Only in Phoenix, Arizona) (FOR LACERA USE ONLY)**

☐ **UnitedHealthcare Group Medicare Advantage**
If you were ever a UnitedHealthcare member when you were under age 65, please include your member number Provider preference. Please specify your selection below:

Physician Name ____________________________________ Number ____________________

Medical Group ____________________________________ Number ____________________

Are you an existing patient? ☐ Yes ☐ No

☐ **SCAN Health Plan**

1. _____ (Initials) I understand that SCAN Health Plan is an MAPD Plan program operating under contracts with CMS. In the event the program is not continued, SCAN Health Plan must assist me in obtaining suitable alternative health care and provision of my Medicare-covered health care will not be interrupted.
2. Please check the state in which you live: ☐ AZ ☐ CA ☐ NV
3. Provider preference. Please specify your selection below:

Physician Name ____________________________________ Number____________________

15 Check the box of the medical plan you want to enroll in and provide any requested information, referring to your plan's provider directory for physician, group and associated ID numbers.

DOE JANE A XXX-XX-XXXX

16 Last Name (Print) First Name (Print) M.I. Social Security Number

16 Fill out name, and Social Security information on the top of page 5.

Section 5

SECTION 5: LACERA Authorization

I understand the LACERA Board of Retirement reserves the right to amend, revise or discontinue these plans and programs at any time. I hereby enroll in the MAPD HMO indicated above. I authorize LACERA to make the necessary deductions from my retirement warrants for any contributions required of me and to send these contributions to the MAPD HMO I have chosen.

17 ______ (Initials) *Please read the information on the back of page 1 and page 2 of this form and initial here before signing. If you submit this form without initialing it, this form will be considered incomplete and the start of your coverage may be delayed.*

Your signature or signature of guardian, conservator or power of attorney* Date

If this is being submitted by a guardian, conservator, or person with power of attorney, please attach the legal documents establishing guardianship, conservatorship or power of attorney.

If anyone helped you fill out any portion of this form, with the exception of the effective date, please have them sign the following:

Signature Date Relationship to Individual

17 Carefully read, initial, date and sign. You must print and physically sign this form. LACERA cannot accept electronic signatures at this time.

Remember to submit **all pages** of this form.