

Thank you for your interest in applying for the ODS Medicare Advantage plan.

If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date.

Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15th to December 7th 2011. This will give you a January 1st 2012 effective date for your new plan. Applications must be signed and dated on, or between October 15th and December 7th 2011. If they are signed prior to October 15th they will be returned to you with a new application. If they are received after December 7th, you will not be able to change plans until the next AEP for January 2013.

This application needs to be reviewed and signed by an Agent before it can be submitted to ODS. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: dann@lowinsure.com
- Mail: CDA Insurance LLC
2160 W 11th Ave
Eugene, Oregon 97402

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.



ODS ADVANTAGE PPO
INDIVIDUAL ENROLLMENT
ELECTION FORM

ODS Health Plan, Inc.
601 S.W. Second Avenue
Portland, OR 97204
503-265-4762 • 877-299-9062
TTY: 711 • Fax: 503-224-1975

901301 (7/11) MDCR-1178

OFFICE USE ONLY:

Name of staff member/agent/broker (if assisted in enrollment): _____
Plan ID #: _____
Effective Date of Coverage: _____
CEP/IEP: ___ OEP: ___ AEP: ___ SEP (type): ___
Not Eligible: _____

Mr. Mrs. Ms.

To enroll in an ODS Advantage PPO plan, please provide the following information:

Last Name	First Name	Middle Initial
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Permanent Residence Address
(P.O. Box is not allowed)

City	State	ZIP Code	County of Residence
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Mailing Address
(if different)

City	State	ZIP Code
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Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Telephone Number ()	Alternate Telephone Number ()
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E-mail Address: _____

Please check which plan you want to enroll in:		Optional Supplemental Benefit:
ODS ADVANTAGE PPORX Select (PPO) <input type="checkbox"/> \$128.30 per month	ODS ADVANTAGE PPO <input type="checkbox"/> \$40.60 per month	ODS ADVANTAGE EXTRA CARE <input type="checkbox"/> \$15.00 in addition to your ODS Advantage PPO plan premium

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.

MEDICARE			HEALTH INSURANCE	
NAME _____				
MEDICARE CLAIM NUMBER _____			SEX _____	
IS ENTITLED TO _____			EFFECTIVE DATE _____	
HOSPITAL (PART A) _____			_____	
MEDICAL (PART B) _____			_____	



PLEASE READ THIS IMPORTANT INFORMATION:

If you currently have health coverage from an employer or union, joining an ODS Advantage PPO plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join an ODS Advantage PPO plan. 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 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 don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't 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 an ODS Advantage PPO 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: _____ BIN _____ PCN _____
Other coverage phone # _____
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) and phone number of institution: _____
4. Are you enrolled in your State Medicaid program? YES NO
If "yes," please provide your Medicaid ID number: _____
5. Do you or your spouse work? YES NO

PAYING YOUR PLAN PREMIUM

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or "Electronic Funds Transfer" (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), 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 ODS Advantage PPO 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. 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. **If you don't select a payment option, you will get a bill each month.**

Please select a premium payment option

- Get a monthly bill
- Electronic funds transfer (EFT) from your bank account each month.
Please enclose a **VOIDED** check or provide the following: Account type: Checking Savings
Account holder name: _____
Bank routing number: _____ Bank account number: _____
- Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

(The Social Security/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.)

Attestation of Eligibility for an Enrollment Period

901301 (7/11) MDCR-1178

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare.
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____.
- I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.
- I recently left a PACE program on (insert date) _____.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- I am leaving employer or union coverage on (insert date) _____.
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

If none of these statements applies to you or you're not sure, please contact ODS Advantage PPO Member Services at **1-877-299-9062** (TTY users should call **711**) to see if you are eligible to enroll. We are open from 7 a.m. to 8 p.m. Pacific Time seven days a week.

Please check the box if you would prefer that we send you information in another format: LARGE PRINT

Please contact ODS Advantage PPO at **877-299-9062** (TTY users should call **711**) if you need information in another format or language other than what is listed above. Our office hours are **7 a.m. to 8 p.m. Pacific time, seven days a week.**

Please Read and Sign Below:

By completing this enrollment application, I agree to the following: ODS Advantage PPO 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 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. 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. 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.

The ODS Advantage PPO plans serve a specific service area. If I move out of the area that the ODS Advantage PPO plans serve, 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 an ODS Advantage PPO 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 ODS Advantage PPO 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 ODS Advantage PPO plan coverage begins, using services in-network can cost less than using services out of network, except for emergency or urgently needed services or out of area dialysis services. If medically necessary, ODS Advantage PPO plan provides refunds for all covered benefits, even if I get services out of network. Services authorized by ODS Advantage PPO plans and other services contained in my ODS Advantage PPO plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR ODS ADVANTAGE PPO 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 an ODS Advantage PPO plan, he/she may be paid based on my enrollment in the ODS Advantage PPO plan.

Release of information: By joining this Medicare health plan, I acknowledge that the ODS Advantage PPO plan will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that the ODS Advantage PPO 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 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.

Your Signature: _____ Today's Date: _____

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

Name: _____ Address: _____

Phone Number: _____ Relationship to Enrollee: _____

If you are an agent contracted with ODS Health Plan, Inc. you must provide the following,

Name: _____ Agency: _____

Date enrollment form received by agent: _____