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

Please be aware of the Annual Enrollment Period (AEP). The 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 they can be submitted to PacificSource. 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.

PacificSource Medicare
PacificSource Community Health Plans, Inc.
2965 NE Conners Avenue, Bend OR 97701
541.385.5315 888.863.3637
Medicare.PacificSource.com

2012 Medicare Advantage Enrollment Form

Lane County Oregon

Please provide your information:

Last Name		First Name	MI	Requested Effective Date		
Birth Date ______/____/_____ MM / DD / YYYY	Sex ☐ M ☐ F	Home Phone Number	County			
Permanent Residence Street Address (**PO Box not allowed**)			City		State	ZIP Code
Mailing Address (only if different from above)			City		State	ZIP Code
Primary Care Provider (not required for Explorer PPO plans)						

Please check the plan you want to enroll in:

☐ Essentials Rx 15 (HMO)	$0 /mo
☐ Explorer 5 (PPO)	$30 /mo
☐ Explorer Rx 4 (PPO)	$78 /mo

Please provide your Medicare insurance information:

Please take out your red, white, and blue Medicare card to complete this section. **You must have Medicare Part A and Part B to join a Medicare Advantage plan.**

Medicare Claim Number: ____________-_________-____________

Please read and answer these important questions:

1. **Do you have End-Stage Renal Disease (ESRD)?**
   ☐ YES ☐ NO If you answered "yes" and you don't need regular dialysis anymore, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant, otherwise we may need to contact you to get additional information.

2. **Are you enrolled in your State Medicaid program?**
   ☐ YES ☐ NO If you answered "yes" include your Medicaid number: _________________________

3. **Will you have other medical and/or prescription drug coverage?**
   (i.e., other private insurance, TRICARE, Federal employee health benefits, or VA benefits)
   ☐ YES ☐ NO If you answered "yes" please provide the following:
   Subscriber Name:______________________ Insurance Company:________________
   ID Number:___________________________ Group Number:___________________
   Effective Date:__________________________ Termination Date:__________________

4. 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:____________________ Phone:__________________________

Address: ____

How did you hear about us? Please select all that apply:

☐ Agent ☐ Friend ☐ Provider ☐ Internet ☐ Newspaper/Magazine ☐ Radio ☐ T.V.

☐ Billboard ☐ Other ________________________________

Paying your plan premium:

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe).

If we determine you owe or have a late enrollment penalty, you will need to choose a premium payment option. People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for up to seventy-five (75) percent 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 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 1-800-MEDICARE or (800) 633-4227, 24 hours per day, 7 days per week. TTY users should call (877) 486-2048. 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.

Please select a premium payment option:

If you don't select a payment option, you will get a bill each month.

☐ **Get a bill.**

☐ **Automatic Deduction from your Social Security deduction or Railroad Retirement Board (RRB) check each month.**

Social Security deductions may take three or more months to begin. If you have a Part D Income related monthly adjustment amount, you will be notified by social security and will be responsonbile for paying this extra amount in addition to your monthly premium. Do not pay PacificSource Medicare. You can either choose to have the amount withheld from your monthly check or be billed directly by social sectuity or RRB. **Please note:** We will bill you for a minimum of three months or until the deductions from your Social Security benefit check go into effect.

☐ **Automatic deduction from checking account each month.**

Convenient monthly withdrawals will be made automatically on the 5th day of every month from my designated checking account. The deduction will also include any outstanding balance on my account. When the deduction falls on a weekend or a holiday, the transfer occurs the next business day. Account funds can only be transferred from checking accounts. Please provide a voided check (deposit slips are not accepted). I have the right to stop payment of a transfer from my account to PacificSource Medicare. I must notify PacificSource Medicare no later than 30 days prior to the deduction date. Please contact Customer Service at the phone number or address above.

I agree to indemnify and hold harmless PacificSource Medicare for any claim arising out of transfers or deductions from my account pursuant to this agreement. I understand that it may take time to process this form through my bank. I agree that until then, I will continue to submit the monthly premium payment directly to PacificSource Medicare.

______________________________ Applicant Name (Print)	______________________________ Accountholder Name (Print)
______________________________ Applicant Signature	______________________________ Accountholder Signature
______________________________ Date	______________________________ Date

Confirm your eligibility for an enrollment period:

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 enrolling during the annual enrollment period between October 15 and December 7.
☐ I am new to Medicare.
☐ I recently moved outside of the service area of my current plan or I recently moved and this plan is a new option for me. I moved 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 received 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, or 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) on (insert date) ________________________.
☐ I am leaving employer or union coverage on (insert date)________________________.
☐ I belong to a pharmacy assistance program provided by my state.
☐ I recently returned to the United States after living permanently outside of the United States. I returned to the Unites States on (insert date) ______________________.
☐ 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 PacificSource Medicare Customer Service using the information provided in the Contact Information section below.

Please read the following sections:

If you currently have health coverage from an employer or union, joining PacificSource Medicare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join our 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.

Release of information:

By joining this Medicare health plan, I acknowledge that PacificSource Medicare will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that PacificSource Medicare will release my information including my prescription drug event data if I have a Medicare Advantage Part D plan 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.

Important information:

PacificSource Medicare 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 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 plan coverage 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. PacificSource Medicare serves a specific service area.

If I move out of the service area, 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 PacificSource Medicare, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from PacificSource Medicare when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage plan. I understand 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 my plan coverage begins, I must get all of my healthcare from PacificSource Medicare, except for emergency, urgently needed services, or out-of-area dialysis services. Premier and Explorer Plan members have the option to receive services from either in-network or out-of-network providers. Please see the Evidence of Coverage document for additional information. I understand that beginning on the date PacificSource Medicare coverage begins, using services in-network can cost less than using services out-of-network, except for emergency, urgently needed services, or out-of-network dialysis services. If medically necessary, PacificSource Medicare provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by PacificSource Medicare 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 PacificSource Medicare will pay for the services.**

Contact information:

Please contact us at (541) 385-5315 or toll-free at (888) 863-3637, 7 days a week. Our hours are:

- **From October 15 to February 14**: 8:00 a.m. to 8:00 p.m. local time zone, seven days a week.
- **From February 15 to October 14**: 8:00 a.m. to 8:00 p.m. local time zone, Monday through Friday.

  Visit our website at www.Medicare.PacificSource.com to enroll online.
  Mail completed forms to PO Box 7469, Bend, Oregon 97708 or fax (541) 382-4217.

Please complete and sign:

Signature: ______________________________ **Today's Date:** ______________

Relationship to beneficiary: ☐ Self ☐ Authorized Representative ☐ Other ____________________

If you are the authorized representative, you must sign above, provide evidence of legal authorization (i.e.: Power of Attorney, another example, etc.), and complete the following information:

Name: ________________________ Address: ______________________________

Phone Number: ____________________ Relationship to Enrollee: ________________________

Check one of the boxes below if you would prefer we send you information in another format:

☐ Large Print or Braille

Please contact Customer Service using the information provided in the Contact Information section above for more information about available alternate formats and languages.

For agent use only:

Agent/Staff Member Name (if assisted in enrollment): Dann Loewenthal

Date Received by Broker/Staff Member: ____________ Agent ID: PM0001901

Previous Plan Type: ☐ MA or MAPD ☐ Other

Previous Plan Term Date: __________________ Plan ID: ____________________________