

Thank you for your interest in applying for the Trillium 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 Trillium. 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.



Individual Enrollment Request Form

Please contact Trillium Community Health Plan® if you need information in another language or format (Braille).

To Enroll in Trillium Community Health Plan Please Provide the Following Information

Please Select Your Trillium Plan Choice

Plans Offered With and Without Supplemental Benefits:

- | | | |
|--|---------------------------------|---------------------------------|
| <input type="checkbox"/> Trillium Advantage HMO | <input type="checkbox"/> Dental | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Trillium Advantage Rx HMO | <input type="checkbox"/> Dental | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Trillium Advantage Rx Smart HMO | <input type="checkbox"/> Dental | <input type="checkbox"/> Vision |

Plans Offered For Special Needs:

- Trillium Advantage Dual SNP HMO
- Trillium Advantage TLC ISNP HMO
- Trillium Advantage TLC Community ISNP HMO

Last Name		First Name			M.I.
Sex	Ethnicity	Birth Date	Home Phone	Emergency Phone	
Permanent Residence Street Address (P.O. Box is not allowed)					
City		State	Zip Code	County	
Mailing Address (if different)					
City		State	Zip Code	County	
Primary Care Provider (First and Last Name)			Established Patient <input type="checkbox"/> Yes <input type="checkbox"/> No		

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 Railroad Retirement Board.

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

Medicare		Health Insurance
Sample Only		
Name _____		
Medicare Claim Number	Sex	_____
_____ - _____ - _____		
Is Entitled To	Effective Date	
Hospital (Part A)	_____	
Medical (Part B)	_____	

Please Read and Answer These 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.

Your Answers to the Following Questions Will Not Keep You From Enrolling in This Plan:

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 Trillium? Yes No

If yes: Name of other coverage: _____

ID Number: _____ Group Number: _____

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 of Institution (Number, Street, City, Zip): _____

Phone Number of Institution: _____

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

6) What is the name of your employer? _____

7) Trillium Advantage TLC ISNP and Trillium Advantage Community ISNP members:

Do you live in one of the following long-term care facilities?

South Hills Green Valley Hillside Heights Applegate Marquis Care

8) 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: Spanish Large Print Audio

Please contact Trillium Community Health Plan at 1(800) 910-3906 (TTY users should call 1(866) 279-9750) if you need information in another format or language than what is listed above. Our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week.

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 benefit or Railroad Retirement (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, 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 Trillium Community Health Plan 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 does not cover.

Please Select a Monthly Payment Option

- Receive a monthly bill
- Electronic funds transfer
- Automatic deduction from your 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.)
- Credit card

If you currently have health coverage from an employer or union, joining Trillium Community Health Plan could affect your employer or union health benefits.

You could lose your employer or union health coverage if you join Trillium Community Health 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.

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

Trillium Community 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 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. Trillium Community Health Plan serves a specific service area. If I move out of the area that Trillium Community Health 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 Trillium Community Health 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 Trillium Community Health Plan when I get it to know which rules I must follow in order 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 Trillium Community Health Plan coverage begins, I must get all of my health care from Trillium Community Health Plan, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Trillium Community Health Plan and other services contained in my Trillium Community Health Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **Neither Medicare nor Trillium Community Health Plan 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 Trillium Community Health Plan, he/ she may be paid based on my enrollment in Trillium Community Health Plan.

Your Signature Is Required On The Back Of This Form

Please Read And Sign Below

Authorization and Declaration

Release of Information: By joining this Medicare health plan, I acknowledge that Trillium Community 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 Trillium Community 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 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: _____ Date: _____

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

Authorized Representative Signature: _____ Date: _____

Address (Number, Street, City, Zip): _____

Phone Number: _____ Relationship to Enrollee: _____



(541) 431-1950 Local
1(800) 910-3906 Toll Free
1(866) 279-9750 TTY
7 Days a Week, 8:00 a.m. - 8:00 p.m.

Please mail this original form to:
Trillium Community Health Plan
PO Box 11756
Eugene, OR 97440
or Fax to: (541) 984-5685

For Office and Agent Use Only

Plan ID Number: _____

Effective Date of Coverage: _____

- ICEP/IEP AEP
 SEP (type) Not Eligible

Representative Name (if assisted in enrollment): _____

Broker Name (if assisted in enrollment):
_____ Dann Loewenthal _____

Agency Name: _____ CDA Insurance LLC _____

Broker Date Stamp: _____