# ODS ADVANTAGE

## INDIVIDUAL ENROLLMENT FORM

*For individuals enrolling in a Medicare PPO plan*

**ODS Health Plan, Inc.**
**601 S.W. Second Avenue • Portland, OR • 97204**
**503-265-4762 • 1-877-299-9062 • TTY: 1-800-433-6313**

**OFFICE USE ONLY:**
Plan ID #: ______
Effective Date of Coverage: ______
ICEP/IEP: ______
OEP: ______
AEP: ______
SEP (type): ______

| MEDICARE NUMBER | | SOCIAL SECURITY NUMBER (optional) | |
|---|---|---|---|
| DATE OF BIRTH | GENDER ❐ M ❐ F | TELEPHONE NUMBER (AREA CODE + NUMBER) | |
| ❐ MR. ❐ MRS. ❐ MS. | LAST NAME | FIRST NAME | MIDDLE INITIAL |

| **PERMANENT RESIDENCE ADDRESS** | | | **MAILING ADDRESS (IF DIFFERENT)** | | |
|---|---|---|---|---|---|
| CITY | STATE | ZIP CODE | CITY | STATE | ZIP CODE |

| MEDICARE ADVANTAGE PLAN CHOICES | PREMIUM |
|---|---|
| ODS ADVANTAGE **PPORX Select**<br>Medical and Enhanced Prescription Drug Plan | ❐ $99.50 |
| ODS ADVANTAGE **PPORX**<br>Medical and Prescription Drug Plan | ❐ $80.90 |
| ODS ADVANTAGE **PPO**<br>Medical Plan *(without prescription drug coverage)* | ❐ $44.10 |
| ODS ADVANTAGE **PPO EXTRA CARE**<br>Optional Supplemental Plan | ❐ $33.00 |

**YOUR PLAN PREMIUM PAYMENT OPTION:** You can pay your Medicare drug plan directly for your monthly premium, or have the monthly premium automatically deducted from your Social Security check. If you choose to pay directly, you can pay by mail or by electronic funds transfer (EFT). Generally, you must stay with the option you choose for the rest of the year. If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want to pay your remaining premium, if there is any, directly to your plan. **Do you want to pay your premium directly to your plan (this can include an automatic monthly deduction from your bank account)? ❐ YES ❐ NO** If you check "no," we will contact you about having your premiums automatically deducted from your Social Security check.

## PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

1. Do you have End Stage Renal Disease (ESRD)? ❐ YES ❐ NO
If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records from your doctor** showing you do not need dialysis or have had a successful kidney transplant.

**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 ODS Advantage? ❐ 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 #: ______

**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 number: ______

**5.** Do you or your spouse work? ❐ YES ❐ NO

**6.** Since you became eligible for Medicare, have you had any prescription drug coverage or any insurance that included drugs? ❐ YES ❐ NO
If you answer "no," your premium may be increased because of a late enrollment penalty. If you answer "yes," we may ask you for proof that your previous prescription drug coverage was at least as good as Medicare's standards prescription drug coverage (creditable prescription drug coverage). You can send copies of your proof with this form or you can wait until we ask for it. You don't have to send your proof to enroll. However, if we ask for your proof and you don't provide it, your premium may be increased because of a late enrollment penalty for more information about the late enrollment penalty, visit www.Medicare.gov or call 1-800-MEDICARE.

# **ODS ADVANTAGE** PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM

*For individuals enrolling in Medicare Part D*

**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** | |
|---|---|
| Medicare Claim No.: | |
| Name: | Sex: |
| Is Entitled to:<br>Part A: ____________ Part B: ____________<br>List effective date in space above: (month/day/year) | |

**PLEASE READ THIS IMPORTANT INFORMATION:** If you currently have health coverage from an employer or union, joining ODS Advantage could affect your employer or union health benefits. If you have health coverage from an employer or union, joining ODS Advantage may change how your current coverage works. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

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**PLEASE READ AND SIGN BELOW:**

**By completing this enrollment application, I agree to the following:** ODS Advantage is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to ODS Advantage or by calling 1-800-MEDICARE. TTY users should call 1-877-486-2048.

ODS Advantage serves a specific service area. If I move out of the area that ODS Advantage 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 ODS Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from ODS Advantage when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

I understand that, beginning on the date my ODS Advantage plan coverage begins, all of my in-network and out of network healthcare claims must be submitted to the ODS Advantage plan. In addition to being covered in the United States, emergency or urgently needed services or out-of-area dialysis services are covered in certain hospitals in Mexico and Canada. I understand that services listed in my ODS Advantage plan Evidence of Coverage document will be covered. I understand that if I use providers that are not part of the ODS Advantage Network for covered services, I may have higher out-of-pocket costs than if I were to use ODS Advantage Network providers (except for emergency or urgently needed care and dialysis 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 healthcare operations. 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 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 ODS Advantage or by Medicare.

Your signature: ______________________ Today's date: ______________________

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

Name: ______________________ Address: ______________________
Phone number: ______________________ Relationship to enrollee: ______________________

As an an agent contracted with ODS Health Plan, Inc., I, ______________________ *(name and agency)*, am authorized to discuss plan options with you. I may be compensated based on your enrollment in a plan.