



ODS ADVANTAGE INDIVIDUAL ENROLLMENT FORM

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): _____

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

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Last Name	First Name	Middle Initial
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Permanent Residence Address

City	State	ZIP Code
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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	County of Residence	Telephone ()
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MEDICARE ADVANTAGE PLAN CHOICES	PREMIUM	MEDICARE ADVANTAGE PLAN CHOICES	PREMIUM
ODS ADVANTAGE PPO_{Rx} Select Medical and Enhanced Prescription Drug Plan	<input type="checkbox"/> \$99.90	ODS ADVANTAGE PPO - Medical Plan without Prescription Drug Coverage	<input type="checkbox"/> \$28.30
ODS ADVANTAGE PPO_{Rx} Medical and Prescription Drug Plan	<input type="checkbox"/> \$77.50	ODS ADVANTAGE PPO EXTRA CARE Optional Supplemental Plan	<input type="checkbox"/> \$33.00

You can pay your monthly plan premium by mail or “Electronic Funds Transfer” (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security check each month. 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. If you don’t select a payment option, you will receive a bill each month. **Please select a premium option:**

- | | |
|--|---|
| <input type="checkbox"/> Receive a monthly bill
<input type="checkbox"/> Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:
Account holder name: _____
Account type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings
Bank routing number: _____
Bank account number: _____ | <input type="checkbox"/> Automatic deduction from your monthly SSA benefit check. (The SSA deduction may take two or more months to begin or end. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.) |
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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.

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 # for this coverage: _____

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

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:	
Hospital (Part A): _____	(Effective date: mo/day/yr)
Medical (Part B): _____	(Effective date: mo/day/yr)

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. I understand that if I do not have Medicare prescription drug coverage or creditable coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage 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, 24 hours a day, seven days a week. 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 Medicare beneficiaries are generally not covered under Medicare while out of country except for limited coverage near the U.S. border.

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. I also acknowledge that ODS Advantage 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 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.