VIVA HEALTH®

Medicare Enrollment Application

Office Use Only:

Name of staff member/agent (if assisted in enrollment): _____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____ OEP: _____

Please contact VIVA MEDICARE if you need information in another language or format (Braille).

To Enroll in VIVA MEDICARE, Please Provide the Following Information:

Please check which plan you want to enroll in:

☐ VIVA MEDICARE *Plus* (HMO)	$ 0 per month	☐ VIVA MEDICARE *Premier* (HMO)	$104 per month
☐ VIVA MEDICARE *Plus* (HMO)	$28 per month	☐ VIVA MEDICARE *Extra Value* (HMO SNP)	$ 0 per month
☐ VIVA MEDICARE *Me* (HMO)	$ 0 per month	☐ VIVA MEDICARE *Select* (HMO)	$ 0 per month
☐ VIVA MEDICARE *Prime* (HMO)	$45 per month		

LAST Name:	FIRST Name:	Middle Initial	Language Spoken

Birth Date: (_____/_____/_____) (M M / D D / Y Y Y Y)	Sex: ☐M ☐F	Home Phone Number: ( )	Cell Phone Number: ( )

Permanent Residence Street Address (P.O. Box is not allowed):

City:	County:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):

Street Address:	City:	State:	ZIP Code:

Emergency contact: _____

Phone Number: _____ **Relationship to You:** _____

E-mail Address:

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

Is Entitled To: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

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

White = Office Yellow = Sales Pink = Member

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 VIVA MEDICARE? ☐ 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 & Phone Number of Institution (Number and Street): _____

4. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If "yes", please provide your Medicaid Number.

Medicaid Number: _____

If enrolling in VIVA MEDICARE *Extra Value* plan, please provide your Social Security Number.

Social Security Number: _____

5. Do you or your spouse work? ☐ Yes ☐ No

Please enter the name of your Primary Care Physician (PCP):

_____

Please check the box below if you would prefer us to send you information in another accessible format:

☐ Audio

Please contact VIVA MEDICARE at 1-800-633-1542 if you need information in another format or language than what is listed above. Our hours are Monday through Friday, 8 a.m. to 8 p.m. (from October 1 to March 31, seven days a week, 8 a.m. to 8 p.m.). TTY users should call 711.

Please Read This Important Information

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

Paying Your Plan Premium

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay 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, 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 the RRB. DO NOT pay **VIVA MEDICARE** ***the Part D-IRMAA.***

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, you will be notified by the Social Security Administration. You will be responsible for paying the 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 VIVA MEDICARE 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 bill each month.

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check and provide the following:

Account holder name: _____

Bank routing number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Bank account number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Account Type: ☐ Checking

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(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.)

Please Read and Sign Below:

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

VIVA 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 only be in 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.

VIVA MEDICARE serves a specific service area. If I move out of the area that VIVA MEDICARE 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 VIVA 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 VIVA MEDICARE 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 VIVA MEDICARE coverage begins, I must get all of my health care from VIVA MEDICARE, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by VIVA MEDICARE and other services contained in my VIVA MEDICARE Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR VIVA MEDICARE 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 VIVA MEDICARE, he/she may be paid based on my enrollment in VIVA MEDICARE.

Release of Information: By joining this Medicare health plan, I acknowledge that VIVA MEDICARE will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that VIVA MEDICARE 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.

Electronic Communication: I consent to be contacted by VIVA MEDICARE, or its business associates, for certain health care communications at the phone number (cellular or landline) and email address above (including voice messages made by an auto-dialer or pre-recorded voice and text messages sent to my cellular number). I understand that my phone or internet carrier may charge fees for these communications (I may contact my carrier for pricing plans and details). I understand that VIVA MEDICARE has policies and procedures in place to safeguard my personal health information; however, there are some data security and privacy risks associated with sending and receiving communications about my health care. Communications I send or receive may not be sent and stored securely and may be accessed by third parties. I understand that I may cancel this consent (revoke or opt-out) by contacting VIVA MEDICARE Member Services.

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.

Signature:	**Today's Date:**

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

Name: _____

Address: _____

Phone Number: (_____) _____ - _____ **Relationship to Enrollee** _____

Witness Signature (required if applicant signs with an X):

_____ Date: _____

White = Office Yellow = Sales Pink = Member