

PERSONAL INFORMATION

Your Name: _____

Date of Birth (month/day/year): _____ Male
 Female

Permanent Residence Address: _____

City _____ State _____ Zip Code _____

Telephone Number: _____ County _____

Mailing Address: (if different from permanent address) _____

City _____ State _____ Zip Code _____

Name of person to contact in case of emergency: [Optional field] _____

Phone Number: [Optional field] _____ Relationship to You: [Optional field] _____

MEDICARE INFORMATION

Please fill in the blanks below with the information on your Medicare card or attach a copy of your Medicare card or your letter of verification from the Social Security Administration or Railroad Retirement Board

Medicare	Health Insurance
CENTERS FOR MEDICARE & MEDICAID SERVICES	
NAME OF BENEFICIARY JANE SMITH	
MEDICARE CLAIM NUMBER 123-45-6789-A	SEX FEMALE
IS ENTITLED TO HOSPITAL (PART A) MEDICAL (PART B)	EFFECTIVE DATE 11-1-98 11-1-98
SIGN HERE	

Social Security # _____

Medicare Claim # _____

Part A (hospital) effective date: _____

Part B (medical) effective date: _____

[Optional field] Please check one of the boxes below if you would prefer us to send you information in a language other than English: Language A (Spanish) Language B (Other _____)

PLAN INFORMATION

Your Medicare Advantage Plan Choice:
 Please check which product you want to enroll in:

- MyAdvantage I
- MyAdvantage I RX
- MyAdvantage II
- MyAdvantage II RX
- MyAdvantage II RX Plus
- MyAdvantage Active
- MyAdvantage Active RX
- MyAdvantage SNP (Dual eligible only)

Office Use Only:

Plan ID #: _____
 Effective Date of Coverage: _____
 ICEP: _____ OEP: _____
 AEP: _____ SEP (type): _____
 H3814 ENDm01_03
 CMS Approved: 8/30/07

Please read and answer these questions:

- Name of chosen Primary Care Physician (PCP): _____
- Do you have End Stage Renal Disease (ESRD)? ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive. Yes No
Note: If 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.

MEDICAL INFORMATION

- Some individuals may have other 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 ATRIO *MyAdvantage*? 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: _____
- Have you recently moved into this plan's service area? Yes No
Your answer to the following questions will not keep you from enrolling in this plan.
- Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)? Yes No
 If yes, name of institution _____
 Address of institution (number and street) _____
 Phone number of institution _____
- Do you receive Medicaid benefits? Yes (If yes, Medicaid Number: _____) No
- Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' Compensation, or VA benefits? Yes No
 If yes, what kind of insurance do you have? _____
 What is the name of your insurance? _____
- Do you or your spouse work? Yes No
- If applicable, agent assignment _____

I understand that my signature on this application means that I have read and understand the contents of this application. Please read your Evidence of Coverage document to know what rules you must follow in order to receive coverage with this Medicare Advantage plan.

Your Signature _____ Date: _____

** If the individual cannot sign, a court-appointed Legal Guardian or person with Durable Power of Attorney for Health Care (DPAHC), if authorized by state law; or another person who is authorized by state law, must sign the following line. Attach a copy of proof of Legal Guardian, DPAHC, or proof of authorization by state law.*

Signature _____ Date: _____

** If anyone helped you fill out this form, she must sign the following line:*

Signature _____ Date: _____ Relationship: _____

STATEMENT OF UNDERSTANDING

1. If you currently have health coverage from an employer or union, joining ATRIO *MyAdvantage* could affect your employer or union health benefits. If you have health coverage from an employer or union, joining ATRIO *MyAdvantage* 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.
2. By completing this enrollment application, I agree to the following:
ATRIO *MyAdvantage* is a Medicare Advantage plan and I will need to keep my Parts A and B. I can be in only 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 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. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to ATRIO Health Plans or by calling 1-800-Medicare. TTY users should call 1-877-486-2048, 24 hours a day/7 days a week.
3. ATRIO *MyAdvantage* serves a specific service area. If I move out of the area that ATRIO *MyAdvantage* 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 ATRIO *MyAdvantage*, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Member Handbook from ATRIO *MyAdvantage* 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 the country except for limited coverage near the U.S. border.
4. I understand that beginning on the date ATRIO *MyAdvantage* coverage begins, I must get all of my health care from ATRIO *MyAdvantage*, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by ATRIO *MyAdvantage* and other services contained in my ATRIO *MyAdvantage* Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR ATRIO *MyAdvantage* WILL PAY FOR THE 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 health care operations. I also acknowledge that ATRIO *MyAdvantage* 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 ATRIO *MyAdvantage* or by Medicare.

Initial