

Paying Your Plan Premium

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 benefit check each month.

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 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 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 we determine that you owe a late enrollment penalty due to a break in Part D coverage, the penalty will be added to your monthly plan premium.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

Automatic deduction from your monthly *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.)

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

Account holder name: _____

Bank routing number: _____

Checking account number: _____

Get a bill each month. You will be responsible for postage to mail your payment.

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 don't need regular dialysis any more, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant.

2. Some individuals may have other health care coverage that pays doctor or hospital bills, including other private insurance, TRICARE, Federal employee health benefits coverage, or VA benefits.

Will you have other health care coverage in addition to VIVA MEDICARE *Plus*? Yes No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage and complete a "Survey of Other Insurance" form.

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage _____

3. 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 *Plus*? Yes No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage and complete a "Survey of Other Insurance" form.

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage _____

4. 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): _____

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

If yes, please mark what type: QMB QMB+ SLMB SLMB+ QI-1 QDWI Full Medicaid

If yes, please provide your Medicaid number: _____

Please choose the name of a Personal Care Physician (PCP) from the VIVA MEDICARE *Plus* Provider Directory:

PCP Name: _____

PCP Number: _____

Provider System Name: _____

Are you an existing patient? Yes No



Please Read This Important Information

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

Please Read and Sign Below:

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

VIVA MEDICARE *Plus* 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 health or 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: November 15-December 31 of every year), or under certain special circumstances.

VIVA MEDICARE *Plus* serves a specific service area. If I move out of the area that VIVA MEDICARE *Plus* 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 *Plus*, 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 *Plus* when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage plan.

I understand that beginning on the date VIVA MEDICARE *Plus* coverage begins, I must get all of my health care from VIVA MEDICARE *Plus* except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by VIVA MEDICARE *Plus* and other services contained in my VIVA MEDICARE *Plus* Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR VIVA MEDICARE *Plus* WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, or other individual employed by or contracted with VIVA MEDICARE *Plus*, he/she may be paid based on my enrollment in VIVA MEDICARE *Plus*.

Release of Information: By joining this Medicare health plan, I acknowledge that my health care providers may release my medical records to VIVA MEDICARE *Plus*. VIVA MEDICARE *Plus* 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 *Plus* 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 by VIVA MEDICARE *Plus* or by 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: _____