


| | | | |
|---|--|-------------|--|
|  | To Enroll in New West Please Provide the Following Information: | | |
| | Please initial the plan in which you wish to enroll: | | _____ New West Medicare \$0 per month _____ New West Medicare Enhanced \$40 per month |
| | Mr. Mrs. Ms. | FIRST name: | LAST Name: Middle Initial |

| | | | |
|--|-------------|--|--------------------|
| Birth Date: (__ / __ / __ __ __ __) (M M / DD / Y Y Y Y) | Sex: M F | Social Security Number: (<i>providing this information is optional</i>) | Home Phone Number: |
|--|-------------|--|--------------------|

Permanent Residence Street Address:

| | | |
|-------|--------|-----------|
| City: | State: | ZIP Code: |
|-------|--------|-----------|


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

Street Address: _____ City: _____ State: _____ ZIP Code: _____

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.

| | |
|--|----------------------|
|  | |
| SAMPLE ONLY | |
| Name: _____ | Sex _____ |
| Medicare Claim Number _____ | _____ |
| Is Entitled To _____ | Effective Date _____ |
| HOSPITAL (Part A) _____ | |
| MEDICAL (Part B) _____ | |

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 New West 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 _____

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

Official's use only
Effective Date: _____ ID# _____

Your Plan Premium 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.

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 standard 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.



Please Read This Important Information

If you currently have health coverage from an employer or union, joining New West could affect your employer or union health benefits. If you have health coverage from an employer or union, joining New West Medicare 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 Sign Below:

New West 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 New West or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

New West serves a specific service area. If I move out of the area that New West 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 New West, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from New West 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 New West coverage begins I should get most or all of my health services from the doctors, hospitals, and other health providers that are part of New West Medicare. I may also use non-plan providers to get covered services. However, if I use non-plan providers for care that is not emergency care, it may cost me more to use them.

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. 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 New West or by Medicare

Your signature _____ Date _____

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

Name : _____

Address: _____

Phone Number: (____) ____ - _____

Relationship to Enrollee _____

OFFICIAL USE ONLY

ICEP/IEP OEP AEP SEP _____

Name of Staff member (if assisted in Enrollment)

NW#185-09-07 H2701

