Stanford | Benefits
University Human Resources

Medicare Advantage Enrollment Form for:

- **Health Net Seniority Plus**
- **Kaiser Permanente Senior Advantage**
- **United Healthcare Group Medicare Advantage**

Keep a copy for your records, and return the completed form to:

Stanford Benefits
P.O. Box 199747
Dallas, TX 75219-9747

For questions, call Stanford Benefits at 650-736-2985, or toll-free at 877-905-2985.

Benefits representatives are available from 7 a.m. to 5 p.m. PST, Monday through Friday, except on holidays.

How a Medicare Advantage Plan Works

Under this retiree medical option, you must be Medicare-eligible and select Health Net Seniority Plus, Kaiser Permanente Senior Advantage or United Healthcare Group Medicare Advantage to provide your medical care.

By signing this form, you assign your Medicare Parts A and B benefits directly to the medical plan you select. Medicare pays your medical plan a fixed fee per month for each member's medical care. This assignment requires that all services (except out-of-area emergency and urgent care) be provided or arranged by your medical plan.

Medicare Advantage Universal Enrollment/Election Form

California Group Plan

Medicare Advantage Plan you are requesting enrollment in:

Employer Group Name (required)	Group #	Requested Effective Date (subject to CMS approval)
Desired Contracting Medical Group (if applicable)	Desired Contracting Physician (if applicable)	Medical Group/Physician No. (if applicable)

Last Name	First Name	MI	Sex ☐ M ☐ F

Permanent Residence Address (Street Address Only—No P.O. Box)

City	State	ZIP	County

Mailing Address if Different (Street, City, State, ZIP)

Daytime Phone Number (including area code)	E-mail address (optional)
Evening Phone Number (including area code)	
Social Security Number (SSN)	Date of Birth

Are you the Subscriber? ☐ Yes ☐ No
If no, provide Subscriber Name and Social Security Number (your group may require this information)

Subscriber Name _____ Subscriber SSN __ __ __-__ __- __ __ __ __

MEDICARE HEALTH INSURANCE CARD INFORMATION

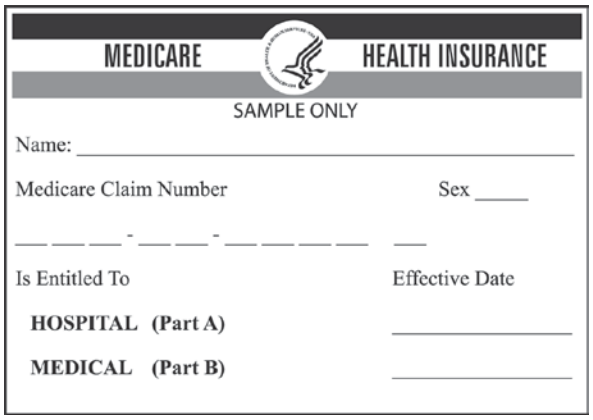
Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

AND/OR–

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

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



1. Are you the retiree? ☐ Yes ☐ No

   If yes, retirement date (month/date/year): _____ /_____ /_____

   If no, name of retiree: _____

2. Are you covering a spouse or dependents under this employer plan? ☐ Yes ☐ No

   If yes, name of spouse: _____

   Name of dependents: _____

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

4. 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.

5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or state pharmaceutical assistance programs.
Will you have other prescription drug coverage? ☐ Yes ☐ No
If yes, please list your other coverage and your identification (ID) number(s) for this coverage.

Name of other coverage: _____

ID # for Coverage: _____

6. 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 of Institution (number and street): _____

Phone Number of Institution: (_____) _____ - _____

Please contact the health plan if you would prefer to receive information in a language other than English or in another format.

By completing this enrollment application, I agree to the following:
This health plan 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. 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. I may leave this plan at any time by sending a request to the health plan or by calling **1-800-MEDICARE** (**1-800-633-4227** or TTY **1-877-486-2048**), 24 hours a day, 7 days a week. However, before I request disenrollment, I will check with my group or union/trust fund to determine if I am able to continue my group membership.

I understand that if I currently have coverage through more than one employer or union/trust fund, I must choose one of these coverage options for my Medicare Advantage plan because I can be enrolled in only one Medicare Advantage plan at a time. My other employer or union/trust fund may allow me to enroll in one of their non-Medicare plans as well. I will contact the benefit administrators at each of my employers or trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or trust fund's plan to select for my Medicare Advantage plan.

I understand that this Medicare Advantage Plan serves a specific service area. If I move out of the area that the Medicare Advantage Plan 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 this Medicare Advantage Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from the Medicare Advantage Plan 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 the Medicare Advantage Plan coverage begins, I must get all of my health care from this Medicare Advantage Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by this Medicare Advantage Plan and other services contained in my *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THIS MEDICARE ADVANTAGE PLAN 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 this Medicare Health Plan will release my information, including any 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/election 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 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.

ARBITRATION AGREEMENT: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 2560.503-1), certain benefit-related disputes), any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

Signature: _____ Date _____

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

Name: _____
(please print)
Address: _____

Phone Number: (_____) _____ - _____

Relationship to Enrollee: _____

DISTRIBUTION: White (Health Plan Copy); Canary (Employer Group Copy); Pink (Medicare Beneficiary Copy)