



Senior Plus (hmo)

## **Important HAP Senior Plus (hmo) Information**

HAP Senior Plus is only available to individuals with Medicare Parts A and B. To enroll in HAP Senior Plus, each Medicare-eligible person must complete their own individual application. Please return completed HAP Senior Plus applications to the WSU Total Compensation and Wellness Department for processing.

Please note that although most HAP HMO participating providers accept HAP Senior Plus, some providers do not participate with HAP Senior Plus. **Please be sure to choose a participating personal care physician.** If your current physician does not participate, please contact Client Services at toll-free (800) 801-1770 and HAP will contact the physician to see if he/she would like to participate.

Disenrollment from HAP Senior Plus can be done at any time during the year. The termination form in the Wayne State University Retiree Handbook must be filled out, signed, and returned to Wayne State University to complete the disenrollment process.

HAP Senior Plus has emergency room and urgent care coverage worldwide. A call to HAP Senior Plus is recommended within 48 hours if admitted into a hospital so your personal care physician can coordinate your care.

If you have any questions regarding HAP Senior Plus, please call the Client Services Department's toll-free number:

**Toll-Free (800) 801-1770**

**Monday through Friday -- 8:00 a.m. - 8:00 p.m.**

**Saturday -- 8:00 a.m. - 12 Noon**

TTY/TDD members can call us at (800) 956-4325.

Or visit us at [hap.org](http://hap.org)



Medicare Advantage HMO
Employer/Union Group Health Plan
Enrollment Request Form

Health Alliance Plan
2850 W. Grand Blvd., Detroit, MI 48202
Telephone (800) 801-1770
TDD (800) 956-4325

To Enroll in HAP Senior Plus (HMO), Please Provide the Following Information:

EMPLOYER or UNION Name: \_\_\_\_\_ GROUP #: \_\_\_\_\_

LAST Name: \_\_\_\_\_ FIRST Name: \_\_\_\_\_ Middle Initial \_\_\_\_\_ [ ] Mr. [ ] Mrs. [ ] Ms.

Birth Date: ( / / ) M M / D D / Y Y Y Y
Sex: [ ] M [ ] F
Home Phone Number: ( )

Permanent Residence Street Address (P.O. Box is not allowed): \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

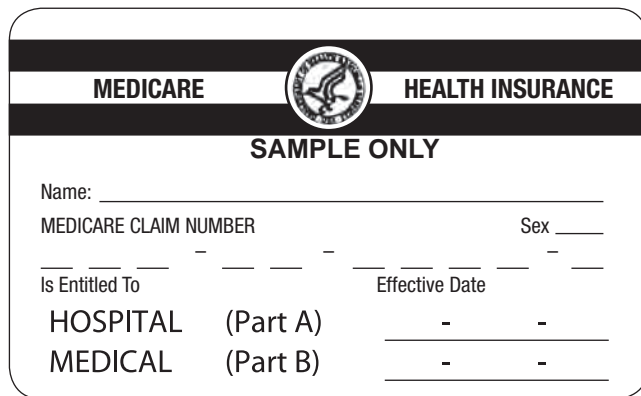
Mailing Address (only if different from your Permanent Residence Address):
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

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 Social Security or the Railroad Retirement Board.

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



Please Read and Answer These Important Questions:

- 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 or union 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 answered "yes" to this question and you don't 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.

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 in addition to HAP Senior Plus?  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 & Phone Number of Institution (number and street): \_\_\_\_\_

Please indicate your choice of Primary Care Physician (PCP), clinic or health center.

**Please check the box below if you would prefer that we send you information in large type:**

Large type

Please contact HAP Senior Plus at (800) 801-1770 if you need information in another format than what is listed above. Our office hours are Monday-Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to noon. TTY users should call (800) 956-4325.

**Please Read and Sign Below:**

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

HAP Senior 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. 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 if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

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

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.

**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 HAP Senior 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 HAP Senior Plus or by Medicare.

**Please keep the yellow copy of your signed form for your personal records.**

**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:** \_\_\_\_\_

**Office Use Only:**

Name of staff member/agent/broker (if assisted in enrollment): \_\_\_\_\_

Plan ID #: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

ICEP/IEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP (type): \_\_\_\_\_ Not Eligible: \_\_\_\_\_