2019 Individual Enrollment Request Form

If you have questions, please contact AgeWell New York at:
1-866-586-8044 or TTY 1-800-662-1220
Fax Enrollment form to 1-855-895-0784

Please contact AgeWell New York if you need information in another language or format (Braille).

PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN	
Bronx, Kings (Brooklyn), Nassau, New York (Manhattan), Queens, & Westchester	
HMO	□ **(H4922-011) LiveWell (HMO) $19** per month □ **Add Optional Dental $16.00** per month □ **Add Optional Vision $9.00** per month □ **(H4922-008) PlanWell (HMO) $86** per month □ **Add Optional Dental $16.00** per month
HMO DSNP	□ **(H4922-003) FeelWell (HMO SNP) $0** per month Full Medicaid (QMB+/SLMB+) or QMB Only
Bronx, Kings (Brooklyn), Nassau, New York (Manhattan), Queens, Suffolk & Westchester	
HMO ISNP	□ **(H4922-004) CareWell (HMO SNP) $0 or up to $39.30** per month

TO ENROLL IN AGEWELL NEW YORK, PLEASE PROVIDE THE FOLLOWING INFORMATION			
LAST Name:	FIRST Name:	Middle Initial:	□Mr. □Mrs. □Ms.
Birth Date: (_____/_____/_____) (MM / DD / YYYY)	Sex: □ M □ F	Home Phone Number: ( )	Alternate Phone Number: ( )
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	County:	State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address):			
City:	State:	ZIP Code:	
Emergency Contact:	**Phone Number:**	**Relationship to You:**	
E-Mail Address:			

PLEASE PROVIDE YOUR MEDICARE INFORMATION	
Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card. -OR- • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Name (as it appears on Medicare card): _____ Medicare Number:_____ Is Entitled to: Effective Date: HOSPITAL (Part A) _____ MEDICAL (Part B) _____ You must have Medicare Part A and Part B to join a Medicare Advantage Plan.

PAYING YOUR PLAN PREMIUM

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail with a personal or certified check each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay AgeWell New York the Part D-IRMAA.

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 local 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 all or 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 you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

□ **Get a bill.**

□ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.**

I get monthly benefits from: □ Social Security or □ Railroad Retirement Board (RRB)

(The Social Security or RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

1. 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 additionalinformation.

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 (EPIC).

Will you have other prescription drug coverage in addition to AgeWell New York? □ 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 facility:_____
Address:_____

City:_____ State:_____ Zip:_____ Tel: (____)_____

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

If yes, do you have coverage through you or your spouse's employer? □ Yes □ No

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

Please choose the name of a Primary Care Physician (PCP), in our network:

PCP name:_____ PCP address_____

City:_____ State:_____ Zip:_____ Tel: (____)_____

New Physician for you □ Yes □ No

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

□ Spanish □ Chinese □ Braille □ Audio tape □ Large print □ Other: _____

Please contact AgeWell New York at 1-866-586-8044 if you need information in an accessible format or language other than what is listed above. Our office hours are 7 days a week from 8:00 am to 8:00 pm Eastern time. TTY users should call 1-800-662-1220.

EMAIL PREFERENCES

Go Green, Go Paperless!

Please provide a valid email address: Member's email: _____

By providing my email address above, I agree to receive email about my benefits, health programs and other plan services. I understand I can change my email preference or opt out of receiving emails at any time by calling Member Services.

Check the box next to each item you wish to receive by email, instead of postal mail.

☐ Annual Notice of Change (ANOC) Kit

☐ Welcome Kit

STOP PLEASE READ THIS IMPORTANT INFORMATION STOP

If you currently have health coverage from an employer or union, joining AgeWell New York could affect your employer or union health benefits. You could lose your employer or union health coverage if you join AgeWell New York. 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:

AgeWell New York 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 be in only 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 prescription drug coverage that I have or may get 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: October 15–December 7 of every year), or under certain special circumstances.

AgeWell New York serves a specific service area. If I move out of the area that AgeWell New York 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 AgeWell New York, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from AgeWell New York 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 AgeWell New York coverage begins, I must get all of my health care from AgeWell New York, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by AgeWell New York and other services contained in my AgeWell New York Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR AgeWell New York 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 AgeWell New York, he/she may be paid based on my enrollment in AgeWell New York.

Release of Information: By joining this Medicare health plan, I acknowledge that AgeWell New York will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that AgeWell New York 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 from 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:**_____

Office/Agent/Broker 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: ____

Enrollment Department Agent/Broker Application Receive Date: _____

Agent/Broker NPN ID#: _____

Please print all information in black ink - keep the yellow copy for your records.

You can Fax this Enrollment Form to **1-855-895-0784**

You can also Mail all other documents or payments to:

AgeWell New York,

1991 Marcus Avenue, Suite M201,

Lake Success, New York, 11042

AgeWell New York, LLC is a Health Maintenance Organization (HMO) plan with a Medicare contract and a Coordination of Benefits Agreement with New York State Department of Health. Enrollment in AgeWell New York, LLC depends on contract renewal. ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-866-586-8044 (TTY: 1-800-662-1220). ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1- 866-586-8044 (TTY: 1-800-662-1220). Assistance services for other languages are also available free of charge at the number above.

Notice of Non-Discrimination

AgeWell New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AgeWell New York does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. AgeWell New York provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact AgeWell New York Member Services at 1-866-586-8044.
If you believe that AgeWell New York has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

AgeWell New York
Civil Rights Coordination Unit
1991 Marcus Avenue Suite M201
Lake Success, New York 11042-2057
1-866-586-8044
TTY/TDD: 1-800-662-1220
Fax: 855-895-0778
Email: civilrightsunit@agewellnewyork.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordination Unit is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, TDD: 1-800-537-7697
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between October 15 and December 7 each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date)_____.
- ☐ I recently was released from incarceration. I was released on (insert date)_____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date)_____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date)_____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date)_____.
- ☐ I recently left a PACE program on (insert date)_____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date)_____.
- ☐ I am leaving employer or union coverage on (insert date)_____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date)_____.

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact AgeWell New York at 1-866-586-8044 (TTY users should call 1-800-662-1220) to see if you are eligible to enroll. We are open 7 days a week from 8:00 am to 8:00 pm Eastern time.

AgeWell New York, LLC is a Health Maintenance Organization (HMO) plan with a Medicare contract and a Coordination of Benefits Agreement with New York State Department of Health. Enrollment in AgeWell New York, LLC depends on contract renewal. ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-866-586-8044 (TTY: 1-800-662-1220). ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1- 866-586-8044 (TTY: 1-800-662-1220). Assistance services for other languages are also available free of charge at the number above.

Notice of Non-Discrimination

AgeWell New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AgeWell New York does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. AgeWell New York provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact AgeWell New York Member Services at 1-866-586-8044.
If you believe that AgeWell New York has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

AgeWell New York
Civil Rights Coordination Unit
1991 Marcus Avenue Suite M201
Lake Success, New York 11042-2057
1-866-586-8044
TTY/TDD: 1-800-662-1220
Fax: 855-895-0778
Email: civilrightsunit@agewellnewyork.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordination Unit is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, TDD: 1-800-537-7697
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

2019 Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.

Medicare Advantage Prescription Drug Plans	
☐	**Medicare Health Maintenance Organization (HMO)** —A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).
☐	**Medicare Special Needs Plan (HMO SNP)** — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: _____**Signature Date:** _____

If you are the authorized representative, please sign above and print below:

Representative's Name: _____ ***Your Relationship to the Beneficiary:*** _____

To be completed by Agent:

Agent Name:	nt Phone:
Beneficiary Name:	eficiary Phone (Optional):
Beneficiary Address (Optional):	
Initial Method of Contact: Walk-in □ Mail □ Phone □ (For Internal Agents Only Date Recorded: _____)	
Agent's Signature:	
Plan(s) the agent represented during this meeting:	
Date Appointment Completed:	

Scope of Appointment documentation is subject to CMS record retention requirements
Agents, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:

AgeWell New York, LLC is a Health Maintenance Organization (HMO) plan with a Medicare contract and a Coordination of Benefits Agreement with New York State Department of Health. Enrollment in AgeWell New York, LLC depends on contract renewal. ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-866-586-8044 (TTY: 1-800-662-1220). ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1- 866-586-8044 (TTY: 1-800-662-1220). Assistance services for other languages are also available free of charge at the number above.

Notice of Non-Discrimination

AgeWell New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AgeWell New York does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. AgeWell New York provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact AgeWell New York Member Services at 1-866-586-8044.
If you believe that AgeWell New York has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

AgeWell New York
Civil Rights Coordination Unit
1991 Marcus Avenue Suite M201
Lake Success, New York 11042-2057
1-866-586-8044
TTY/TDD: 1-800-662-1220
Fax: 855-895-0778
Email: civilrightsunit@agewellnewyork.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordination Unit is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, TDD: 1-800-537-7697
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.