



Please contact KelseyCare Advantage if you need information in another language or format (Braille).



**To Enroll in KelseyCare Advantage, Please Provide the Following Information:**

Please check the plan you are enrolling in:		County of Residence: ( <b>You must live in one of these 8 counties</b> )	
KelseyCare Advantage Preferred Rx \$49.00 /month	<input type="checkbox"/> Harris <input type="checkbox"/> Ft. Bend <input type="checkbox"/> Montgomery <input type="checkbox"/> Galveston		
	<input type="checkbox"/> Brazoria <input type="checkbox"/> Chambers <input type="checkbox"/> Liberty <input type="checkbox"/> Waller		

LAST Name:	FIRST Name:	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
------------	-------------	----------------	---

Birth Date: ( ___ / ___ / ___ ) M M D D Y Y Y Y	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number:	Alternate 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):

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

**Email Address:**

**Please Provide Your Medicare Insurance Information**

<p>Please take out your red, white and blue Medicare card to complete this section.</p> <ul style="list-style-type: none"> <li>Fill out this information as it appears on your Medicare card.</li> <li>-OR-</li> <li>Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.</li> </ul>	Name (as it appears on your Medicare card): _____
	Medicare Number: _____
	Is Entitled to: _____ Effective Date: _____
	<b>HOSPITAL (Part A)</b> _____
	<b>MEDICAL (Part B)</b> _____ You must have Medicare Part A and Part B to join a Medicare Advantage plan.

**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 additional information.

**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 KelseyCare Advantage?  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:
-------------------------	-----------------------	----------------------------

<p><b>3. Are you a resident in a long-term care facility, such as a nursing home?</b>   <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>If "yes," please provide the following information: Name of Institution: _____  Address &amp; Phone Number of Institution (number and street): _____</p>
<p><b>4. Are you enrolled in your State Medicaid program?</b>   <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>If yes, please provide your Medicaid number: _____</p>
<p><b>5. Do you or your spouse work?</b>   <input type="checkbox"/> Yes   <input type="checkbox"/> No</p>
<p><b>Please choose the name of a Primary Care Physician (PCP):</b></p>
<p><b>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:</b>   <input type="checkbox"/> Spanish   <input type="checkbox"/> Braille   <input type="checkbox"/> Large Print   Other _____</p> <p>Please contact KelseyCare Advantage at 713-442-CARE (2273) if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. to 5 p.m., Monday-Friday. TTY users should call 1-866-302-9336.</p>



**Please Read and Sign Below**

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

KelseyCare Advantage 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. 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, or under certain special circumstances.

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

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

<b>Signature:</b>	<b>Today's Date:</b>
If you are the authorized representative, you must sign above and provide the following information:	
<b>Name:</b> _____ <b>Address:</b> _____	
<b>Phone Number:</b> (____) _____ - _____ <b>Relationship to Enrollee</b> _____	
<b>Office Use Only:</b>	
Name of staff member/agent/broker (if assisted in enrollment): _____	
Plan ID #: _____ Effective Date of Coverage: _____	
ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____	
Agent Signature: _____ Date: _____ Agent ID: _____	

### Attestation of Eligibility for an Enrollment Period

**Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of 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 KelseyCare Advantage at 713-442-CARE (2273) or toll free at 1-800-663-7146 (TTY users should call 1-866-302-9336) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., 7 days a week.