

Individual Enrollment Request Form

Please contact SCAN[®] Health Plan Arizona if you need information in another language or format (Braille).

Step 1: Please fill out the application completely. Use a ballpoint pen and press hard to make three copies.

Step 2: Sign and date the application.

Step 3: Keep the BOTTOM copy for your file.

If you have any questions regarding this application, please call 1-866-563-7396, 8:00 A.M.–8:00 P.M., 7 days per week (TTY users: 1-800-367-8939, 8:00 A.M.–8:00 P.M., 7 days per week).

1313 E. Osborn Road, Suite 150, Phoenix, AZ 85014

TOP COPY—Enrollment Services

MIDDLE COPY—Finance

BOTTOM COPY—Member

H9385_SCAN_6596_2011 CMS Approved 090211

2011 F-APP-ALL 09/11

Please contact SCAN® Health Plan Arizona if you need information in another language or format (Braille).
 Por favor comuníquese con SCAN® Health Plan Arizona si necesita información en cualquier otro idioma o formato (Braille).

1 | To Enroll in SCAN Health Plan Arizona, Please Provide the Following Information:

Please check which plan you want to enroll in:
SCAN Connections (HMO SNP) 001 Maricopa County \$0 per month
SCAN Classic (HMO) 002 Maricopa & Pima Counties \$0 per month

Last Name: _____ First Name: _____ M.I.: _____ Mr./Mrs./Ms.
 Birth Date: ____ / ____ / _____ Sex: Male Female Home Phone #: (____) _____
 Permanent Residence Street Address (PO Box is not allowed):


 City: _____ State: _____ Zip Code: _____
 Mailing Address (only if different from your Permanent Residence Address):
 Street Address: _____
 City: _____ State: _____ Zip Code: _____
 Emergency Contact (optional): _____
 Phone Number: (____) _____ Relationship to You: _____

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:
 Preferred Written Language: English Spanish Braille
 Preferred Spoken Language: English Spanish Sign Language/TTY
 Please contact SCAN at **1-888-540-7226** if you need information in another format or language than what is listed above. Our office hours are 7 A.M.–8 P.M., 7 days per week. TTY users should call 1-800-367-8939.

2 | Physician Information

Please choose the name of a Primary Care Physician (PCP).
 Physician Name: _____ Physician ID Number: _____
 Is this a new physician for you? Yes No

3 | Please Provide Your Medical Insurance Information:

Please take out your Medicare card to complete this section. <ul style="list-style-type: none"> 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.	 MEDICARE HEALTH INSURANCE SAMPLE ONLY
	Name: _____
	Medicare Claim Number: _____ Sex: _____
	Is Entitled to: _____ Effective Date: _____
	HOSPITAL (Part A): _____ MEDICAL (Part B): _____

5 | Please Read and Answer These Important Questions (continued)

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 Number of Institution (Number and Street): _____

4. Are you enrolled in your State Medicaid program, Arizona Health Care Cost Containment System (AHCCCS)? Yes No

If "yes," please provide your AHCCCS number: _____

5. Do you or your spouse work? Yes No

6. If you are applying for SCAN Connections, are you enrolled in Arizona Long Term Care System (ALTCS)? Yes No

If "yes" please provide the information below:

Program Contractor: _____

6 | Please Read This Important Information

If you currently have health coverage from an employer or union, joining SCAN Health Plan Arizona could affect your employer or union health benefits. You could lose your employer or union health coverage if you join SCAN Health Plan Arizona. 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.

7 | Please Read and Sign Below

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

SCAN Health Plan Arizona 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 have not maintained Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's) I may have to pay a late enrollment penalty. 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.

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

7 | Please Read and Sign Below (continued)

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

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 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 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 have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date): _____
- 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.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- None of these statements applies to me.*

* Please contact SCAN Health Plan Arizona at 1-866-563-7396 (TTY users should call 1-800-367-8939) to see if you are eligible to enroll. We are open 8:00 A.M.–8:00 P.M., 7 days per week.

OFFICE USE ONLY

NAME OF STAFF MEMBER/AGENT/BROKER (if assisted in enrollment): _____ REP. CODE: _____

EFFECTIVE DATE OF COVERAGE ____/____/____	ICEP/IEP: <input type="checkbox"/>	AEP: <input type="checkbox"/>	SEP (TYPE): <input type="checkbox"/>	NOT ELIGIBLE: <input type="checkbox"/>	REC'D DATE: _____
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(M M / D D / Y Y Y Y)

CHECK THE APPROPRIATE BOX(ES) ABOVE

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