

# Arcadian Health Plan

10025 W. Markham St., Suite 220, Little Rock, AR 72205

## Individual Enrollment Request Form Plus (HMO) Individual Enrollment Request Form

**To Enroll in Arcadian Health Plan, Please Provide the Following Information:**

**Please check which plan you want to enroll in:**  
 Arcadian Health Plan – Plus (HMO): Adair and Delaware counties: \$0 monthly  
 Arcadian Health Plan – Plus (HMO): Ottawa county: \$0 monthly

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

Birth Date: ( __ / __ / ____ ) MM/DD/YYYY	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: (    )
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Permanent Residence Street Address: \_\_\_\_\_

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




Street Address:	City:	State:	ZIP Code:
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Emergency Contact:	Phone Number: (    )	Relationship to You:
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E-mail Address: \_\_\_\_\_

Yes  No I would like to receive information from the plan via email. (This excludes HIPAA protected information and CMS required documents.)

**Please Provide Your Medicare Insurance Information**

<p>Please take out your Medicare card to complete this section.</p> <ul style="list-style-type: none"> <li>• Please fill in these blanks so they match your red, white and blue Medicare card</li> <li>-OR-</li> <li>• Attach a copy of your Medicare card or your letter from Social Security or Railroad the Retirement Board.</li> </ul> <p><b>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</b></p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Medicare</td> <td style="width: 33%; text-align: center;"></td> <td style="width: 34%;">Health Insurance</td> </tr> <tr> <td colspan="3" style="padding: 5px;">SAMPLE ONLY</td> </tr> <tr> <td colspan="3">Name: _____</td> </tr> <tr> <td>Medicare Claim Number: _____</td> <td colspan="2">Sex: _____</td> </tr> <tr> <td colspan="3">_____ - _____ - _____</td> </tr> <tr> <td>Is Entitled to</td> <td colspan="2">Effective Date</td> </tr> <tr> <td><b>HOSPITAL (Part A)</b></td> <td colspan="2">____/____/____</td> </tr> <tr> <td><b>MEDICAL (Part B)</b></td> <td colspan="2">____/____/____</td> </tr> </table>	Medicare		Health Insurance	SAMPLE ONLY			Name: _____			Medicare Claim Number: _____	Sex: _____		_____ - _____ - _____			Is Entitled to	Effective Date		<b>HOSPITAL (Part A)</b>	____/____/____		<b>MEDICAL (Part B)</b>	____/____/____	
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<b>MEDICAL (Part B)</b>	____/____/____																								

**Paying Your Plan Premium:**

**If we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail, Electronic Funds Transfer (EFT) or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.**

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% of 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](http://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

Electronic Funds Transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: \_\_\_\_\_

Bank routing number: \_\_\_\_\_

Bank account number: \_\_\_\_\_

Account type:  Checking  Savings

Credit Card Please provide the following information:

Type of Card: \_\_\_\_\_

Name of Account holder as it appears on the card: \_\_\_\_\_

Account number: \_\_\_\_\_

Expiration Date: \_\_\_\_/\_\_\_\_ (MM/YYYY)

Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

**Please Read and Answer These Important Questions:**

1. Do you have End Stage Renal Disease (ESRD)?  Yes  No

If you answered "yes" to this question and you don't need regular dialysis anymore, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant.

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 Arcadian Health Plan?  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 institution: \_\_\_\_\_

Address and phone number of institution (number and street): \_\_\_\_\_

\_\_\_\_\_

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

**Please select a Primary Care Physician (PCP) from the Provider Directory:**

PCP Provider Code: \_\_\_\_\_

**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:**

Spanish  Other languages: \_\_\_\_\_  Large Print

Please contact Arcadian Health Plan at 1-800-573-8597 if you need information in another format or language than what is listed above. Our office hours are 8am – 8pm, Sunday – Saturday. TTY users should call 1-866-573-8591.



**Please Read This Important Information:**

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

Arcadian 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 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: November 15 – December 31 of every year), or under certain special circumstances, by sending a request to Arcadian Health Plan or by calling 1-800-MEDICARE. TTY users should call 1-877-486-2048, 24 hours a day/7 days a week.

Arcadian Health Plan serves a specific service area. If I move out of the area that Arcadian Health 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 Arcadian Health 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 Arcadian Health Plan when I get it to know which rules I must follow in order 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 Arcadian Health Plan coverage begins, I must get all of my health care from Arcadian Health Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Arcadian Health Plan and other services contained in my Arcadian Health Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR ARCADIAN HEALTH PLAN 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 Arcadian Health Plan, he/she may be paid based on my enrollment in Arcadian Health Plan. 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.*

