



**Office Use Only:** Representative Name (if assisted with enrollment) \_\_\_\_\_  
 Effective Date of Coverage: \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
 ( ) ICEP/IEP ( ) OEP ( ) AEP ( ) SEP ( ) Not Eligible

**PartnershipAdvantage (HMO)**

Please contact PartnershipAdvantage (HMO) if you need information in another language or format (Braille).

**To Enroll in PartnershipAdvantage (HMO), Please PRINT the Following Information**

Last Name		First Name		Middle Initial
Permanent Residence Address <i>(P.O. Box is not allowed):</i>		City	State	Zip Code
Mailing Address <i>(if different from above)</i>		City	State	Zip Code
Home Phone Number  (____) ____ - ____	Alternate Phone Number  (____) ____ - ____	Date of Birth  ____/____/_____ (MM/DD/YYYY)	Sex:  <input type="checkbox"/> M <input type="checkbox"/> F	

**Please Provide Your Medicare Health Insurance Claim Number**

- This number can be found on your Red, White, and Blue Medicare Card.
  - You must have Medicare Part A and Part B to join PartnershipAdvantage (HMO).
- Medicare Claim Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Please Complete The Following Personal Information (Optional)**

What is your race?  White  Black or African American  American Indian or Alaska Native  
 Asian  Native Hawaiian or Other Pacific Islanders  Two or more races  Other \_\_\_\_\_

What is your ethnicity?  Hispanic or Latino  Not Hispanic or Latino

What is your spoken language at home?  English  Spanish  Russian  Tagalog  
 Other \_\_\_\_\_

Would you like us to send you information in another language or format?  
 Other Language:  Spanish  Other \_\_\_\_\_  
 Other Format:  Large Font  Braille  Audio CD  Other \_\_\_\_\_

Please contact PartnershipAdvantage (HMO) at 1 (866) 249-9933 if you need information in another format or language than what is listed above. Our office hours are 8am to 8pm 7 days a week. TTY users should call 1 (800) 735-2922

Do you need interpreter services when you receive medical care?  Yes  No

**Please Read, Answer the Following Questions, and Sign Below**

Do you have End Stage Renal Disease (ESRD)?  Yes  No  
 Diagnosis Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)

If you answered “yes” to this question and you don’t need regular dialysis any more, 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.

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 so Partnership *Advantage* (HMO)?

Yes  No

If “yes,” please list your other coverage and your identification numbers for this coverage:

**(Please do not list your current Part D or Medicare Advantage Plan. Partnership *Advantage* (HMO) will replace your current Part D or Medicare Advantage Plan.)**

Name of other coverage:

ID # for this coverage:

Group # for this coverage:

Do you currently receive Medi-Cal benefits from Partnership HealthPlan of California (PHC)?

•You must have full-scope Medi-Cal, with no “share-of-cost” through PHC to enroll in Partnership *Advantage* (HMO).

Yes  No If yes, please provide your ID # on your Purple and White PHC ID Card:

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

Please choose a Primary Care Physician (PCP) from the Partnership *Advantage* (HMO) Provider Directory.

If you do not choose a PCP at the time of enrollment, you may be automatically assigned to your current PHC Medi-Cal provider.

PCP Name:

PCP ID # (found in the Provider Directory):

**Please Read Page 3 of this Document Prior to Signing the Application Below**

Your Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**If you are the “Authorized Representative,” you must provide the following information:**

Name:

Relationship to beneficiary:

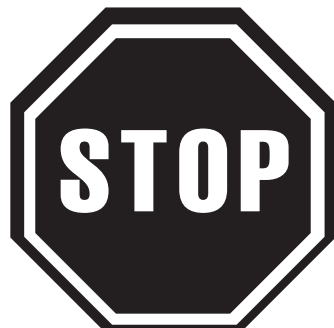
Address:

Phone Number:

City:

(\_\_ \_\_ \_\_) \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
State: Zip Code:

**STOP! Please Read This Important Information**



If you currently have health coverage from an employer or union, joining Partnership *Advantage* (HMO) could affect your employer or union health benefits. You could lose your employer or union health coverages if you join Partnership *Advantage* (HMO). 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.

**By completing this enrollment application, I agree to the following:** Partnership*Advantage* (HMO) is a Medicare Advantage plan and has a contract with the Federal Government. I will need to keep my Medicare Parts A and B, and full-scope, no share-of-cost Medi-Cal. 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: November 15 - December 15 of every year), or under certain special circumstances. If I continue to qualify for Medi-Cal, I may change plans at any time during the year. Partnership*Advantage* (HMO) serves a specific service area. If I move out of the area that Partnership*Advantage* (HMO) services, 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 Partnership*Advantage* (HMO), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Partnership*Advantage* (HMO) when I receive it to know which rules to get coverage with this Medicare Advantage plan. I understand that people with Medicare beneficiaries 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 Partnership*Advantage* (HMO) begins, I must get all of my health care from Partnership*Advantage* (HMO), except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Partnership*Advantage* (HMO) and other services contained in my Partnership-*Advantage* (HMO) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR PARTNERSHIP*ADVANTAGE* (HMO) 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 Partnership*Advantage* (HMO), he/she may be paid based on my enrollment in Partnership*Advantage* (HMO). Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medi-Cal program and the Medicare Savings Program.

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