



To Enroll in American Health Medicare, Please Provide the Following Information Please contact American Health Medicare if you need information in another language or format (Braille).

**Please check which plan you want to enroll in:**

AHM\_Platino Plus (HMO SNP) \$0 per month

Mr.  Mrs.  Ms.



Last name:

name:

Sex:

Dia:  Año:   F  M

Phone:

Alt. phone:

Address

State:  Zip Code:

State:  Zip Code:

In case of emergency please contact:

phone:

## Favor de proveer su información de Seguro de Medicare

Please take out your Medicare card to complete this section:

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 the Social Security Administration or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

MEDICARE			HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)				
NAME OF BENEFICIARY				
MEDICARE CLAIM NUMBER		SEX		
IS ENTITLED TO		EFFECTIVE DATE		
<b>HOSPITAL MEDICAL</b>		<b>(PART A)</b>		
		<b>(PART B)</b>		

Paying Your Plan Premium

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

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 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.

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 American Health Medicare 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 (Reforma)? Yes \_\_\_ No \_\_\_

If yes, please provide your Medicaid Number (Reforma): \_\_\_\_\_

5. Do you or your spouse work? Yes \_\_\_ No \_\_\_

Special Needs Plan: Do you live in a long term care facility? Yes \_\_\_ No \_\_\_

Special Needs Plan: Do you have diabetes: Yes \_\_\_ No \_\_\_

Please choose the name of a Primary Care Physicians (PCP), clinic or health center:

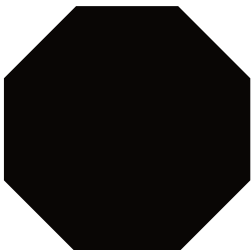
Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

\_\_\_\_\_ Spanish

\_\_\_\_\_ Braille Format \_\_\_\_\_ Audio Format

Please contact American Health Medicare at 1-888-620-1919 if you need information in another format or language than what is listed above. Our office hours are Monday through Friday from 8:00 am to 8:00 pm.

TTY users should call 1-866-620-2520



Please Read this Important Information

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

American Health Medicare is a Medicare Advantage Plan with a contract with the Federal Government and the Health Insurance Administration (ASES, in spanish) for Medicare Platino. I will need to keep my Parts A and B and the Government of Puerto Rico Health Insurance (Reforma). 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. Dual Eligible (those who are in Reforma) can move in and out of this plan on a monthly basis, by sending a request to American Health Medicare. For other plans that are not Platino, 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.

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

By joining this plan, I confirm that I am not getting any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) to buy medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or part, my enrollment in a Medicare Advantage or Medicare Prescription Drug Plan.

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

Signature: X \_\_\_\_\_ 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 Use Only:

Name of staff member/agent/broker (if assisted in the enrollment): \_\_\_\_\_

Plan ID# \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

ICEP/IEP: \_\_\_\_\_ OEP: \_\_\_\_\_ AEP: \_\_\_\_\_

SEP(type): \_\_\_\_\_ Not Eligible: \_\_\_\_\_