



101 S.E. Third Street • Evansville, IN 47708

Member ID# _____ Proposed Effect. Date ___/___/___
Existing WHP Member ID# (If Applicable) _____

Individual Enrollment Request Form

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

SECTION 1: To Enroll in WHP Medicare Advantage Plans, Please Provide the Following Information:

Please check which plan you want to enroll in:

- WHP Silver (HMO) (without prescription drug coverage), \$0/mo.
- WHP Silver Rx (HMO) (includes prescription drug coverage), \$61/mo.
- WHP Platinum Rx (HMO) (includes prescription drug coverage), \$99/mo.
- Platinum Select Rx (HMO-POS) (includes prescription drug coverage), \$201/mo.

LAST Name: _____ FIRST Name: _____ Middle Initial _____ Mr. Mrs. Ms.

Birth Date: (MM/DD/YYYY) _____ Sex Male Female Home Phone Number: _____

Permanent Residence Address (P.O. Box is not allowed): _____

City: _____ State: _____ ZIP Code: _____ County: _____

E-mail Address: _____

Mailing Address (only if different from your Permanent Residence Address): _____

City: _____ State: _____ ZIP Code: _____ County: _____

SECTION 2: Please provide Your Medicare Insurance Information


Please take out your Medicare card to complete this section.

- Please fill in the blanks at right 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 both Medicare Part A & Part B to join a Medicare Advantage Plan.

MEDICARE			HEALTH INSURANCE	
Name _____				
Medicare Claim Number _____			Sex _____	
_____ - _____ - _____				
Is Entitled To:			Effective Date:	
Hospital (Part A)			____/____/____	
Medical (Part B)			____/____/____	

SECTION 3: Choose a Primary Care Physician (PCP) from the plan's Provider Directory

Provider Name: _____ PCP ID (see directory): _____

SECTION 4: Paying Your Plan Premium

You can pay your monthly plan premium including any late enrollment penalty that you currently have or may owe by mail or "Electronic Funds Transfer" (EFT) 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% or more of your 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.

PLAN USE ONLY: Please Do Not Complete This Section

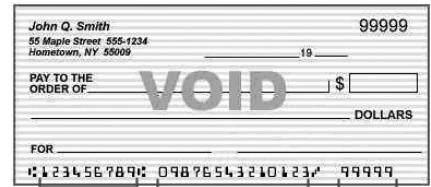
Application Received Date: _____ Application Entered Date: _____

SECTION 4: Paying Your Plan Premium (Continued)

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 monthly
- Electronic funds transfer (EFT) from your bank account each month.
A **VOIDED Check or Deposit Ticket must be included for this option**
Account type: Checking Savings
- 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.)



SECTION 5: Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. Additionally, 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 enrolling during the Annual Election Period (AEP).
- 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 Welborn Health Plans 7 days a week, 8 a.m. to 8 pm. at 1-800-521-0265 (TTY users should call 1-800-743-3333) to see if you are eligible to enroll.

SECTION 6: 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. 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 of Institution: _____ Phone number of Institution _____

3. Are you currently working? Full-time Part-time Retired N/A

Is your spouse currently working? Full-time Part-time Retired N/A

4. Will you have any **OTHER** insurance besides Welborn Health Plans Medicare Advantage when WHP becomes effective? Yes No (skip to # 6)

If "yes" is OTHER coverage through:
 My current / previous employer My spouse's current / previous employer
 Other (skip to # 5)

If your coverage is through an employer please provide the following information:

Employer name:	Phone #:
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How many employees work for your employer? 1-19 20-99 100 or more Don't know

5 Please provide the following information:

Name of Insurance Company:	Phone #:
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Group #:	ID #:
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Type of coverage: <input type="checkbox"/> Medical <input type="checkbox"/> Drug <input type="checkbox"/> Both	Date coverage began:	Date coverage ended:
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6. Do you have coverage as a Veteran (VA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No ID#
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Are you enrolled in your State Medicaid Program?	<input type="checkbox"/> Yes <input type="checkbox"/> No ID#
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Do you have Hoosier Rx?	<input type="checkbox"/> Yes <input type="checkbox"/> No ID#
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Do you have Federal Retirees Coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No ID#
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Date this plan began:	Date this plan ended:
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Please Read This Important Information



If you currently have health coverage from an employer or union, joining the WHP Silver Rx (HMO), WHP Platinum Rx (HMO) or the Platinum Select Rx (HMO-POS) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join the WHP Silver Rx (HMO), WHP Platinum Rx (HMO) or the Platinum Select Rx (HMO-POS). 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.

Application continued on next page



SECTION 7: Please Read and Sign Below

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

Welborn Health Plans (WHP) 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.

WHP Silver (HMO) Only: 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 (**Example: November 15 – December 31 of every year**), or under certain special circumstances.

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

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

Applicant Signature:*	Today's Date:
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**If you are the authorized representative, you must sign above and provide the following information:*

Name:	Phone Number:	Relationship to Enrollee:	
Street Address:	City:	State:	ZIP Code:

FOR AGENT/BROKER USE ONLY—Please Do Not Complete the following Sections.

Agent/Broker Use ONLY:
Agent/Broker Name (printed) _____ Agent No. _____
Agency Name _____
Phone No. _____ Fax No. _____
Agent/Broker Signature _____ Date _____



AUTHORIZATION TO RELEASE PERSONAL MEDICAL INFORMATION
(In order for this form to be valid, it must be fully completed.)

NAME OF MEMBER: _____

MEMBER ID #: _____ BIRTHDATE: _____ AGE: _____

Please complete and Mail or Fax to: Welborn Health Plans, ATTN: Enrollment
101 S.E. Third Street
Evansville, IN 47708
Fax: 716-541-6322

YOU ARE HEREBY AUTHORIZED TO RELEASE TO:

(Name of Person to Receive Information) _____

(Address and Fax Number) _____

THE INFORMATION SPECIFIED BELOW FOR THE FOLLOWING PURPOSE:

- To assist me with regard to claims and treatment
Other: _____

I understand that this authorization is subject to revocation by me (us) at any time except to the extent that action has been taken in reliance thereon; in which case, I understand that my revocation will not affect the uses and disclosures of such information, which have been before receipt of the revocation. I also understand that any information, which is released pursuant to this Authorization, may not longer be subject to the Privacy Rules which otherwise protect the privacy of such information. I also understand that this authorization will expire sixty (60) days from the date signed unless otherwise specified.

- (Date, event or condition on which authorization expires if other than 60 days)
Until I am no longer covered under Welborn Health Plans.

INFORMATION TO BE RELEASED

Signature of Member Date Signed

Street Address of Member Signature of Other Authorized Person*

City, State, Zip Relationship to Member

Phone Number of Member

Signature of Witness

* Authorization must be signed by the parent or legal guardian of any member under 18, the legal guardian of any member under guardianship, the personal representative of a deceased member, or if no personal representative the spouse of a deceased member, or if no spouse, any adult child of a deceased member (Chapter 8 of I.C. 16-4 - Acts of 1982). If member is under 18 and records are protected by Federal Law (42 CRF Part 2) regarding drug and alcohol abuse, authorization must be signed by both member and parent or legal guardian.