



A plan for life.

2011 Member Application

CDPHP[®] Medicare Choices Group HMO and Group PPO Plans

(collectively referred to herein as CDPHP Group Medicare Plans)

**Capital District Physicians' Health Plan, Inc.
CDPHP Universal Benefits,[®] Inc.
(CDPHP)**

500 Patroon Creek Blvd.
Albany, NY 12206-1057

(518) 641-3950 or 1-888-248-6522

TTY/TDD (518) 641-4000 or 1-877-261-1164

(for people with hearing or speech difficulties)

Fax: (518) 641-5006

8 a.m. to 8 p.m., Monday through Friday



A plan for life.

2011 Group Medicare Member Application

Please print and use ink. If you have any questions as you complete this application, please contact your employer or union health benefits department. Or, call (518) 641-3950 or 1-888-248-6522. TTY/TDD users should call (518) 641-4000 or 1-877-261-1164.

Date Received @
CDPHP

FOR EMPLOYER GROUP OFFICE USE ONLY

Employer Group Admin Initials <i>(required)</i> :	Effective Date:	QE or Reason: <input type="checkbox"/> ICEP/IEP <input type="checkbox"/> OEP <input type="checkbox"/> AEP <input type="checkbox"/> SEP
---	-----------------	---

Questions marked with an asterisk (*) are required. You must answer these questions to complete this application.

*Employer or Union Name: _____ *Group #: _____ HMO
 PPO

*1. First Name: _____ MI: _____ *Last Name: _____ Mr. Mrs. Ms.

*2. Permanent Residence Address *(this address cannot be a P.O. Box)*:
Address/Apt. # _____ City _____ State _____ ZIP _____ County _____

3. Mailing Address *(only if different from your Permanent Residence Address)*:
Address/P.O. Box/Apt. # _____ City _____ State _____ ZIP _____ County _____

4. Telephone Number: (____) _____ - _____ *5. Date of Birth: ____/____/____ *6. Gender: Male Female

7. Emergency Contact:
Relationship to You: _____ Telephone: (____) _____ - _____

8. Name of chosen Primary Care Physician *(complete for CDPHP Medicare Choices Group HMO plans only)*:
Physician Name: _____
Physician ID#: _____ Current Patient? Yes No

*9. 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 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: **HOSPITAL (Part A)** _____ / _____ / _____
MEDICAL (Part B) _____ / _____ / _____

10. 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: Large Print Compact Disc

Please contact CDPHP Medicare Choices at (518) 641-3950 or 1-888-248-6522 if you need information in another format or language than what is listed above. Our office hours are 8 a.m. to 8 p.m., Monday to Friday. TTY users should call (518) 641-4000 or 1-877-261-1164.

2011 CDPHP Group Medicare Member Application

Questions marked with an asterisk (*) are required. You must answer these questions to complete this application.

***11.** 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 do not need dialysis or you have had a successful kidney transplant.

12. 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 Facility: _____ Phone Number: _____

Address of Facility (number and street): _____

***13.** Are you enrolled in your state Medicaid program? Yes No

If “yes,” please provide your Medicaid number: _____

Some individuals may have other health and/or prescription drug coverage options, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs (e.g., EPIC).

***14a.** When your CDPHP Group Medicare coverage takes effect, will you (on your own or through your spouse) have other **health insurance** in addition to CDPHP, including the types listed above? Yes No

If “yes,” please list the name of your other coverage and your identification number:

Insurance Carrier Name: _____ Policyholder Name: _____ ID #: _____

***14b.** When your CDPHP Group Medicare coverage takes effect, will you (on your own or through your spouse) have other **prescription drug coverage** in addition to CDPHP, including the types listed above? Yes No

If “yes,” please list the name of your other coverage and your identification number:

Insurance Carrier Name: _____ ID #: _____ RxBIN #: _____

***15.** Are you the retiree? Yes No

If “yes,” retirement date: ____ / ____ / ____

If “no,” name of retiree: _____

***16.** Are you covering a spouse or dependents under this employer or union plan? Yes No

If “yes,” name of spouse: _____

Name of dependents: _____

Please contact your group administrator for assistance in enrolling eligible family members. A separate application is needed for each person to be enrolled in this plan.

***17a.** When your CDPHP Group Medicare coverage takes effect, will you be working? Yes No

***17b.** When your CDPHP Group Medicare coverage takes effect, will your spouse be working? Yes No N/A

STOP PLEASE READ THE IMPORTANT INFORMATION ON THE REVERSE AND SIGN BELOW: STOP

Applicant's Signature:	Today's Date:
If you are the applicant's authorized representative, you must provide the following information:	
Name: _____	
Address: _____	
Telephone Number: (_____) _____ - _____ Relationship to Applicant: _____	
Attach a copy of proof of Legal Guardian, DPAHC, written advance directive, or proof of authorization by state law.	

I affirm that I discussed all CDPHP Group Medicare health and prescription drug benefit options with this applicant.

CDPHP Representative / Broker / Agent's Signature (if applicable)	Broker Code:	Today's Date:
---	--------------	---------------

2011 CDPHP Group Medicare Member Application

STOP PLEASE READ THIS IMPORTANT INFORMATION: STOP

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

CDPHP 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. It is my responsibility to inform you of any prescription drug coverage that I already have or may get in the future. 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 benefit period. Once I enroll, I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to my employer or union health benefits department.

CDPHP Group Medicare Plans serve a specific service area. If I move out of the area that my CDPHP Group Medicare 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 a CDPHP Group Medicare 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 my CDPHP Group Medicare Plan when I receive it to know which rules I must follow in order to receive 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 my CDPHP Group Medicare Plan coverage begins, I must get all of my health care in accordance with my CDPHP Group Medicare Plan, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by my CDPHP Group Medicare Plan and other services contained in my CDPHP Group Medicare Plan's *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization unless otherwise indicated, **NEITHER MEDICARE NOR MY CDPHP GROUP MEDICARE 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 CDPHP Group Medicare Plans, he/she may be paid based on my enrollment in CDPHP Group Medicare Plans.

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.

Release of Information:

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that my CDPHP Group Medicare Plan 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 behalf of the individual under the laws of the state where the individual resides) 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 my CDPHP Group Medicare Plan or by Medicare.

**Please submit your completed, signed application to your
employer or union health benefits department.**

Or, mail it to:

**CDPHP GROUP MEDICARE ENROLLMENT
500 PATROON CREEK BLVD.
ALBANY, NY 12206-1057**

You also can fax your completed, signed application to (518) 641-5006.