



A plan for life.

2008 Individual Enrollment Application Medicare PPO

CDPHP Universal Benefits, Inc. (CDPHP UBI)
500 Patroon Creek Blvd.
Albany, NY 12206-1057

(518) 641-3400 or 1-888-519-4455
TTY/TDD (518) 641-4000 or 1-877-261-1164
(for people with hearing or speech difficulties)
8 a.m.–8 p.m. Monday–Friday
Fax: (518) 641-4606

For instructions on how to complete this form, see page 5.

Internal Use Only	
Eff Date:	Group #:
Div #:	Rep Code:
Election Period:	CY:
Date Stamp <i>(received)</i>	Date Stamp <i>(completed)</i>



Medicare PPO Enrollment Application

Please print and use ink. If you have any questions as you complete this application, please call (518) 641-3400 or 1-888-519-4455. TTY/TDD users should call (518) 641-4000 or 1-877-261-1164.

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

SECTION 1: YOUR CURRENT PERSONAL AND MEDICARE INFORMATION

*1. First Name:	MI:	*Last Name:	Suffix:
*2. Permanent Residence Address:			
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. Social Security Number:	*6. Date of Birth:	
() -	- -	/ /	
7. Primary Language:		*8. Gender:	
<input type="checkbox"/> English <input type="checkbox"/> Other (please indicate)		<input type="checkbox"/> Male <input type="checkbox"/> Female	
9. Emergency Contact:			
Relationship to You:		Telephone: () -	
*10. Please take out your Medicare Card to complete this section.		MEDICARE HEALTH INSURANCE	
<ul style="list-style-type: none"> 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 Railroad Retirement Board. <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>		Name: _____ Medicare Claim Number: _____ Sex: ____ ____ - ____ - _____ Is Entitled To: _____ Effective Date: _____ HOSPITAL (Part A) ____ / ____ / ____ MEDICAL (Part B) ____ / ____ / ____	

SECTION 2: YOUR PRODUCT AND PAYMENT METHOD SELECTIONS

*11. Please check which product you wish to enroll in:
<input type="checkbox"/> CDPHP Medicare PPO Value—\$9 per month <input type="checkbox"/> CDPHP Medicare PPO with Part D—\$25 per month <input type="checkbox"/> CDPHP Medicare PPO with Part D Plus—\$35 per month <i>These 2008 monthly premiums may be less for low-income subsidy beneficiaries.</i>
*12. Optional Preventive Dental Benefits (check appropriate box):
<input type="checkbox"/> Please <u>add</u> the optional preventive dental benefit to my plan selection for an additional cost of \$12.70 per month. <input type="checkbox"/> I am not interested in adding the optional preventive dental benefit to my plan selection for 2008.

CDPHP Medicare PPO Individual Enrollment Application

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

SECTION 2: YOUR PRODUCT AND PAYMENT METHOD SELECTIONS (CONTINUED)

You can pay your monthly plan premium by mail or by Electronic Funds Transfer (EFT). You can also choose to pay your premium by automatic deduction from your Social Security Check each month. Generally, you must stay with the option you choose for the rest of the year.

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 does not cover.

*13. Please select a premium payment option. If you don't select a payment option, we will bill you each month.

Bill me each month. Please enter your Billing Address (**only** if different than your Mailing Address):


Address/P.O. Box/Apt. # City State Zip County

Deduct my premium from my bank account monthly using Electronic Funds Transfer (EFT). (You will be notified of the effective date of withdrawals. Until then, please continue to submit premium payments by mail.) Please enclose a VOIDED check with this application and provide the following:

Bank Name _____ Branch _____

Account Holder Name _____

Checking Account Number _____ Bank Routing Number _____

(You can find your routing number on the bottom of your checks, usually between a facing pair of symbols. Routing numbers are nine digits long. If you cannot find the number on your check, your bank will be able to provide this information for you. Here is a sample routing number )

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

SECTION 3: YOUR ELIGIBILITY AND INSURANCE STATUS

*14. 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 have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

*15. 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: _____ Phone Number: _____

Address of Institution (number and street): _____

*16. Are you enrolled in your State Medicaid program? Yes No

If "yes," please provide your Medicaid number: _____

CDPHP Medicare PPO Individual Enrollment Application

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

SECTION 3: YOUR ELIGIBILITY AND INSURANCE STATUS (CONTINUED)

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 (i.e., EPIC).

*17a. When your CDPHP Medicare PPO coverage takes effect, will you (on your own or through your spouse) have other **health insurance** in addition to CDPHP Medicare PPO, 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 #:
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*17b. When your CDPHP Medicare PPO coverage takes effect, will you (on your own or through your spouse) have other **prescription drug coverage** in addition to CDPHP Medicare PPO, 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 #:	Group #:
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*18a. When your CDPHP Medicare PPO coverage takes effect, will you be working? Yes No

*18b. When your CDPHP Medicare PPO coverage takes effect, will your spouse be working?
 Yes No Not Applicable



STOP! PLEASE READ THE INFORMATION ON THE REVERSE BEFORE SIGNING THIS FORM!



19. To my satisfaction, the following CDPHP Medicare PPO topics have been explained to me by CDPHP Medicare-approved literature and/or one of its employees or authorized agents (**initial next to each item**):

- _____ Medical benefits and cost sharing
- _____ Part D Prescription Drug benefits and cost sharing
- _____ Low Income Subsidy for Prescription Drug premiums and cost sharing, if applicable

Applicant's
Signature

Today's
Date

If you are the Applicant's authorized representative, you must provide the following information:

Name: _____

Address: _____

City, State, Zip: _____

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 Medicare PPO health and prescription drug benefit options with this Applicant.

CDPHP UBI Representative/Broker/
Agent's Signature (if applicable)

Broker
Code:

Today's
Date:

Please MAIL your completed, signed Application in the enclosed envelope, or to:

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

You also can FAX your completed, signed Application to (518) 641-4606.

CDPHP Medicare PPO Individual Enrollment Application



STOP! PLEASE READ THIS IMPORTANT INFORMATION:



If you currently have health coverage from an employer or union, joining CDPHP MEDICARE PPO could affect your employer or union health benefits. If you have health coverage from an employer or union, joining CDPHP MEDICARE PPO may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their Web site, or contact the office listed in their communications. If there is no 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:

CDPHP MEDICARE PPO is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I do not 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. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to CDPHP MEDICARE ENROLLMENT or by calling 1-800-MEDICARE. TTY users should call 1-877-486-2048, 24 hours a day/7 days a week.

CDPHP MEDICARE PPO serves a specific service area. If I move out of the area that CDPHP MEDICARE PPO 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 CDPHP MEDICARE PPO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from CDPHP MEDICARE PPO when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date CDPHP MEDICARE PPO coverage begins, I must get all of my health care from CDPHP MEDICARE PPO, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by CDPHP MEDICARE PPO and other services contained in my CDPHP MEDICARE PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR CDPHP MEDICARE PPO WILL PAY FOR THE SERVICES.**

Release of Information:

By joining this Medicare health plan, I acknowledge that CDPHP MEDICARE PPO will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that CDPHP MEDICARE PPO 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 CDPHP MEDICARE PPO or by Medicare.

HOW TO COMPLETE YOUR CDPHP UBI ENROLLMENT APPLICATION

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

SECTION 1—YOUR CURRENT PERSONAL AND MEDICARE INFORMATION

Please provide your personal and emergency contact information, including permanent address (this cannot be a P.O. Box) and mailing address (if different from your personal address). Also, please provide your current Medicare insurance information.

SECTION 2—YOUR PRODUCT AND PAYMENT METHOD SELECTIONS

Select the CDPHP Medicare PPO Plan you wish to join. If a Broker, Agent, or Plan Representative is assisting you, ask him/her detailed questions regarding Plan differences, if needed. Also, choose how you would like to pay your premium. If you want to receive a monthly invoice by mail, indicate if your billing address is different than your mailing address.

SECTION 3—YOUR ELIGIBILITY AND INSURANCE STATUS

In this section, please identify any other insurance you will have as of your effective date with CDPHP Medicare PPO. If you will have other drug coverage, your ID # and Group # can be found on your drug plan member card. We also need to know if you have End Stage Renal Disease (ESRD), if you reside in a skilled nursing facility, rehabilitation hospital, or other institution, and if you receive Medicaid benefits.

Please be sure to carefully read all information and sign this Application. If the enrollee is unable to sign, a legal representative or an individual authorized to act on the enrollee's behalf may sign instead, provided a copy of a document such as a "Power of Attorney" form or authorized representative form is submitted with the Application. Return the fully completed, signed Application (TOP COPY) to CDPHP UBI in the postage-paid envelope provided, or fax it to the number shown below. **Please keep the BOTTOM COPY as your temporary ID card.**

Please MAIL your completed, signed Application in the enclosed envelope, or to:

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

Phone: (518) 641-3400 or 1-888-519-4455 TTY/TDD users call (518) 641-4000 or 1-877-261-1164

You also can FAX your completed, signed Application to: (518) 641-4606

NOTE: You may qualify for extra help with your Medicare Prescription Drug Plan coverage.

If you qualify for extra help with your Medicare Prescription Drug Plan costs, Medicare will help pay your monthly premium, yearly deductible, and prescription copayments. When you join a CDPHP Medicare PPO Plan with Part D, Medicare will tell us how much extra help you are getting. Then, we will let you know how much you will pay. Enrollees interesting in qualifying for extra help with Medicare Prescription Drug Plan costs should call:

- 1-800-MEDICARE (1-800-633-4227), 24 hours a day/7 days per week. TTY/TDD users should call 1-877-486-2048, or
- The Social Security Administration at 1-800-772-1213, TTY/TDD users should call 1-800-325-0778.