



VANTAGE MEDICARE
A D V A N T A G E



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Office of Group Benefits Medicare Advantage Enrollment Application
For Medicare Eligible State of Louisiana Retirees

READ THIS FIRST: By completing this application, you are requesting enrollment in the Vantage Medicare Advantage Plan with Prescription Drug Coverage offered exclusively to Louisiana State Retirees through the Office of Group Benefits. Please review all statements on this application. Please provide the Information requested below, sign and date the last page, and return. **NOTE:** A separate application is required for each person enrolling in the plan.

Last Name	First Name	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date: ____ / ____ / ____ <small>Month Day Year</small>	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number: ____ - ____ - ____ <small>(providing this information is optional)</small>	Home Phone Number: (____) ____ - ____
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Permanent Residence Street Address:

City:	State: Parish:	ZIP Code:
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Mailing Address (only if different from your Permanent Residence Address):

Street:	City:	State:	ZIP Code:
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Please Provide your Medicare Insurance Information

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 Railroad Retirement Board.

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



SAMPLE CARD ONLY

Name: _____

Medicare Claim Number _____ Sex _____

_____ - _____ - _____

Is Entitled to _____ Effective Date _____

HOSPITAL (Part A) _____ - _____ - _____

MEDICAL (Part B) _____ - _____ - _____

Paying Your Plan Premium

Your monthly plan premium will be automatically deducted from your retirement check if you receive money from your state retirement fund. If you do not receive money from your state retirement fund, you will continue to make premium payments to the Office of Group Benefits.

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 do not 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.

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 Vantage Health Plan? Yes No

If "yes" please list your other coverage and your identification (ID) number(s) for the other 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 facility: _____

Address of Facility: _____

Phone number for facility: _____

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

If yes, please provide your Medicaid number: _____

5. Do you or your spouse work? Yes No

Please choose the name of a Primary Care Physician (PCP):

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

Spanish Chinese Other language: _____

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Vantage Health Plan could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Vantage Health Plan may change how your current coverage works. Read the communications your employer or union sends you. If you have any questions, visit their website or contact your local health benefits office.

Please read and Sign Below

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

Vantage Health Plan is a Medicare Advantage plan, not a supplement to Original Medicare, and I will need to keep my Parts A and B. I understand that I will continue to pay my Part B premium. 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. 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 Vantage Health Plan or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

Vantage Health Plan serves a specific service area. If I move out of the area that Vantage Health 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 Vantage Health Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Vantage Health Plan when I receive it to know which rules I must follow in order to receive coverage with the Vantage Medicare Advantage plan.

I understand that beginning on the date Vantage Medicare Advantage coverage begins I must get all of my health care coverage through Vantage Medicare Advantage with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare Advantage while out of the country except for limited coverage in Canada and Mexico. Services authorized by Vantage Health Plan, Inc. and other services contained in my Vantage Medicare Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **WITHOUT AUTHORIZATION, NEITHER MEDICARE NOR VANTAGE HEALTH PLAN, INC. WILL PAY FOR THE SERVICES.**

Release of Information:

By joining this Medicare Advantage health plan, I acknowledge that Vantage Health Plan will release my information to Medicare and other plans as is necessary for treatment, payment and operations. I also acknowledge that Vantage Health 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 on this application (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) 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 Vantage Health Plan or by Medicare.

Your Signature: _____

Today's Date: _____

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

Name: _____

Address: _____

Phone Number: (_____) _____

Relationship to Enrollee: _____

Office Use Only:

Name of staff member (if assisted in enrollment): _____

Plan ID Number: _____ Effective Date of Coverage: _____

ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____