



A plan for life.

**2010 Individual Enrollment Application
CDPHP® Medicare Choices
PPO Plans**

(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)

Fax: (518) 641-4606

Monday – Friday, 8 a.m. to 8 p.m.

(Monday through Sunday from November 15, 2009 – March 1, 2010)

and 8:30 a.m. - 5 p.m. thereafter

CDPHP Medicare Choices PPO Plans 2010 Enrollment Application

Please contact CDPHP Medicare Choices if you need information in another language or format (Braille).

TO ENROLL IN CDPHP MEDICARE CHOICES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Please check which plan you want to enroll in:

<input type="checkbox"/> CDPHP Core (PPO) — \$28 per month	<input type="checkbox"/> CDPHP Core Rx (PPO) — \$49.60 per month
<input type="checkbox"/> CDPHP Classic (PPO) — \$49 per month	<input type="checkbox"/> CDPHP Classic Rx (PPO) — \$79.60 per month
<input type="checkbox"/> CDPHP Prime (PPO) — \$120 per month	<input type="checkbox"/> CDPHP Prime Rx (PPO) — \$170.60 per month

LAST Name: _____ Mr. Mrs.
 Ms.

FIRST Name: _____ **Middle Initial:** _____

Birth Date: ____/____/_____ (MM)/(DD)/(YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: (____) ____-____	Alternate Phone Number: (____) ____-____
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Permanent Residence Street Address (P.O. Box is not allowed):

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

City: _____	State: _____	ZIP Code: _____
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Emergency Contact:
 Phone Number: _____ Relationship to You: _____

Email Address:

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

<p>Please take out your Medicare card to complete this section.</p> <ul style="list-style-type: none"> Please fill in these blanks so they match your red, white, and blue Medicare card. <p style="text-align: center;">-OR-</p> <ul style="list-style-type: none"> Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>	 <p>MEDICARE HEALTH INSURANCE</p>
	<p>SAMPLE ONLY</p> <p>Name: _____</p> <p>Medicare Claim Number: _____ Sex: _____</p> <p>_____ - _____ - _____</p> <p>Is Entitled To: _____ Effective Date: _____</p> <p>HOSPITAL (Part A) _____ / _____ / _____</p> <p>MEDICAL (Part B) _____ / _____ / _____</p>

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PAYING YOUR PLAN PREMIUM

You can pay your monthly premium 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 coinsurance. 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.

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 each month

Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account Holder Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Account Type: Checking Saving

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.)

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 CDPHP Medicare Choices? 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 & Phone Number of Institution (number and street): _____

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 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

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STOP PLEASE READ THIS IMPORTANT INFORMATION STOP

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

CDPHP Medicare Choices 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. 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.

CDPHP Medicare Choices serves a specific service area. If I move out of the area that CDPHP Medicare Choices 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 Choices, 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 Choices 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 CDPHP Medicare Choices coverage begins, using services in network can cost less than using services out of network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, CDPHP Medicare Choices provides refunds for all covered benefits, even if I get services out of network. Services authorized by CDPHP Medicare Choices and other services contained in my CDPHP Medicare Choices *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with CDPHP Medicare Choices, he/she may be paid based on my enrollment in CDPHP Medicare Choices.

Release of information: By joining this Medicare health plan, I acknowledge that CDPHP Medicare Choices 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 Choices 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 CDPHP Medicare Choices or by Medicare.

Signature:

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 enrollment): _____

Signature: _____ Broker ID#: _____

Plan ID#: _____ Effective Date of Coverage: _____

ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

DATE RECEIVED



A plan for life.

CDPHP Universal Benefits®, Inc.
500 Patroon Creek Blvd.
Albany, NY 12206-1057

www.cdphp.com/medicare