



Individual HealthPartners® Freedom Medical Plan Enrollment Form - for Minnesota residents

Each individual must complete a separate enrollment form.

You are eligible to join the HealthPartners® Freedom plan if:

- You are enrolled in the Federal Medicare Program for Part A (hospital coverage) AND Part B (medical coverage) or you are enrolled in Part B only. If you have Medicare Part B only, you will only have coverage for Medicare Part B services. You will not have coverage for hospital, skilled nursing facilities, and related services covered by Medicare Part A; and
- You live in the plan's service area. This eligibility condition does not apply if you are already a commercial member of HealthPartners. However, if you move to a different out-of-area address after the initial enrollment, the Centers for Medicare and Medicaid (CMS) requires HealthPartners to disenroll you from the plan; and
- You DO NOT have End Stage Renal Disease (ESRD). ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive. If you have ESRD, you cannot enroll in this plan unless you are already a commercial member of HealthPartners and developed ESRD while you were a non-Medicare member; and

Important information:

- After we receive your enrollment form, we will send your member identification card and a letter stating when your coverage begins. HealthPartners must receive your completed, signed and dated enrollment form by the last working day of the month before you want coverage to begin. Coverage always begins on the first day of a future month.

- If you would like your HealthPartners premiums to be paid directly from a bank account, complete the Authorization for Direct Payment in this packet and attach a voided check or savings deposit slip.

To enroll, please follow these steps:

- 1) Fill out ALL of the enrollment form except shaded areas. Incomplete or incorrect enrollment forms may delay the effective date of your coverage. Use a ball-point pen and print firmly to ensure clear carbon copies.
- 2) Provide a PHOTOCOPY of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board with this enrollment form. **Or you may fill out the information in Section Three exactly as it appears on your Medicare card.**
- 3) Select one medical plan option:
 - Plan I
 - Plan II
 - Plan III
- 4) **Carefully read, sign and date the enrollment form.**
- 5) **Retain the color copy for your records.** Send the white copy to HealthPartners in the enclosed postage-paid envelope.

Please put all of your completed applications from this enrollment kit in the same envelope.

Mail applications to:

Riverview Membership Accounting - MS21103R
PO BOX 9463
Minneapolis, MN 55440

HealthPartners is a health plan with a Medicare contract.

Individual HealthPartners® Freedom Medical Plan Enrollment Form

SECTION ONE: Personal information

Broker Name JAY PETERSON
Agency No. 3818
HEALTHPARTNERS USE ONLY
Eff. Date _____
MR# _____
Ctct # _____

 Last Name First Name M. I. Social Security Number

 Date of Birth (MM/DD/YY) Home Phone (area code) Work Phone (area code)

 Permanent Home Address Apt. No.

 City State ZIP Code County

 Mailing Address (if different from permanent home address) Apt. No.

 City State ZIP Code County

Male Female

SECTION TWO: Medical plan and billing information

Choose **ONE** medical plan option:

- Plan I - \$55 *See important note below.
- Plan II - \$84
- Plan III - \$122

IMPORTANT NOTE: HealthPartners® Freedom Medical Plan I is not eligible for any Medicare Prescription Drug (Part D) plans offered through HealthPartners. If you wish to apply for one of the HealthPartners Medicare Prescription Drug plans, you must be enrolled in Medical Plan II or III.

To enroll in a HealthPartners® Freedom Medicare Prescription Drug plan, you must also complete the Medicare Prescription Drug Program Enrollment Form that is included in your HealthPartners® Freedom packet.

Choose ONE

Plan Payment Options:

Generally you must stay with the option you choose for the rest of the year.

- Monthly Direct Payment (electronic fund transfer from your bank account)
 To enroll, please complete the separate Direct Payment Authorization form included in your enrollment kit and return it with this enrollment application.
- Monthly Billing Quarterly Billing
- Automatic deduction from your 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 THREE: Medicare information

Please take out your Medicare card to complete this section.

Please fill in the blank card to the right so it matches 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.

Health Insurance	
SOCIAL SECURITY ACT	
NAME OF BENEFICIARY _____	
CLAIM NUMBER _____	SEX _____
IS ENTITLED TO _____	
HOSPITAL INSURANCE (PART A) _____	EFFECTIVE DATE _____
MEDICAL INSURANCE (PART B) _____	_____
SIGN HERE	

SECTION FOUR: Please answer the following questions

1. Do you have End Stage Renal Disease (ESRD)? ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive. If your answer is YES, you cannot enroll in this plan unless 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. If you have ESRD, you cannot enroll in this plan unless you were already enrolled in a HealthPartners plan as a commercial member. YES NO

2. Are you currently enrolled in another Medicare health plan that you intend to keep in addition to the HealthPartners® Freedom plan? If YES, please include the insurance name and address and policyholder name and number. YES NO

By enrolling in HealthPartners® Freedom Plan, you may be canceling your membership in your current plan. Please call HealthPartners if you have questions.

Your answers to the following questions will not affect your eligibility for enrollment in this plan.

3. Are you now or have you ever been a HealthPartners member? YES NO
 If YES, please give your identification number (to avoid duplication): _____

4. Do you receive Medicaid benefits? YES NO
 If YES, what is your Medicaid number? _____

For MAC use only AEP SEP

SECTION FIVE: Authorization and acknowledgement

Generally, I can be a member of only one Medicare medical plan and one Medicare Prescription Drug Program at a time. By enrolling in this plan, I will automatically be disenrolled from any other Medicare medical plan, including a Medicare Health Plan (Medicare Advantage and Medicare Cost plans) of which I am currently a member. I understand that since I can be a member of only one Medicare plan at a time, I cannot enroll in more than one Medicare plan with the same effective date of coverage. If I do this, my enrollments may be canceled and I will have to fill out a new enrollment form to become a member of a Medicare plan.

I must keep my Medicare Parts A and/or B. I must continue to pay the premiums for my Medicare Parts A and/or B.

“Effective date of coverage” is when I should begin using the plan’s services. The plan will still send me final approval of my enrollment in the plan. I understand that I should not disenroll from any Medicare supplement plan, or Medigap or Medicare Select plan until I get that approval from the plan.

Beginning on the date HealthPartners® Freedom Plan coverage begins, I will receive all of my health care from HealthPartners, with the exception of emergency or urgently needed services. In addition to being covered in the United States, emergency and urgently needed services are covered in certain hospitals in Mexico and Canada. If I do not receive care from HealthPartners, I will be liable for all applicable Medicare deductibles and coinsurance amounts. I may also be liable for any charges not covered by Medicare. HealthPartners will not cover these services.

I may disenroll by sending a written request to the plan or by calling 1-800-MEDICARE, (1-800-633-4227) 24 hours a day/7 days a week (TTY: 1-877-486-2048 for the hearing and speech impaired). Until the effective date of disenrollment, I must keep getting health care from the HealthPartners® Freedom plan doctors to receive plan coverage.

As a member of the plan, I have the right to appeal the plan’s decision about payment or services if I disagree.

I must tell HealthPartners before I move out of the service area. I understand that if I move permanently out of the service area, Medicare requires HealthPartners to disenroll me.

It is my job to tell HealthPartners about other prescription drug coverage I may have. If I intentionally misrepresent this information, Medicare requires the plan to disenroll me.

If I currently have health coverage from an employer or union group, enrolling in other coverage could affect my employer or union health benefits. I should discuss my decision to enroll in a Medicare plan with my benefits administrator.

HealthPartners® Freedom plan is a Medicare Cost plan.

Release of Information: By joining this Medicare health plan, I allow the Centers for Medicare & Medicaid Services (CMS) to give information to the plan. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B). I also allow the plan’s doctors or clinics or anyone else with medical or relevant information about me to give CMS or CMS’ agents the information needed to run the Medicare program.

I also acknowledge that HealthPartners 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 guidelines.

I understand that my signature on this application means that I have read and understand the contents of this application. To find out more about the rules and procedures you must follow in order to receive coverage, please read the HealthPartners® Freedom Evidence of Coverage. (This will be sent to you automatically once you are enrolled or upon request.)

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.

Generally, enrollment begins the first day of the month after HealthPartners receives your completed form and verifies your eligibility.

STOP Do you currently have health coverage from an employer or union group? If so, talk with your benefits administrator about your decision to join this plan as it could affect your employer or union health benefits.

Your Signature* _____ Date _____
* If the individual cannot sign, a court-appointed legal guardian or person with Power of Attorney, if authorized by state law; or another person who is authorized by state law, must sign the following line. Attach a copy of proof of Legal Guardian, Power of Attorney, or proof of authorization by state law.

Signature _____ Date _____

If anyone helped the applicant fill out this form, she or he must sign below:

Please sign here: _____ Relationship: _____ Date: _____

For questions regarding medical and dental plans, call 952-883-5601 or 1-800-247-7015, Monday - Friday, 8 a.m. to 6 p.m. TTY users should call 952-883-6060 or 1-800-443-0156.

For questions about Medicare Part D prescription drug benefits, including copayments, deductibles and network pharmacies, call 952-883-5601 or 1-800-247-7015, seven days a week, 8 a.m. to 8 p.m. TTY users should call 952-883-6060 or 1-800-443-0156.



8170 33rd Avenue South
PO BOX 1309
Minneapolis, MN 55440-1309

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HEALTHPARTNERS® FREEDOM (INDIVIDUAL) ENROLLMENT FORM

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