Enrollment Request Form

Please contact Essence Healthcare if you need information in another language or format (Braille).

Filling out and returning the enrollment request form is your first step to becoming a member of Stanford Health Care Gold (HMO) or Stanford Health Care Platinum (HMO) offered by Essence Healthcare. If you and your spouse are both applying, you'll each need to fill out a separate form. For help completing the enrollment form, call our Member Services Contact Center at 1-855-996-8422 (TTY: 711), 8 a.m. to 8 p.m., 7 days a week. You may receive a messaging service on weekends from April 1 through September 30 and holidays.

How to fill out this form

1. Answer all questions and print your answers using black or blue ink.

2. Sign the form on page 6 and date it. **Make sure you've read all the pages before you sign.**

3. Mail the original, signed form to:
   P.O. Box 12487, St. Louis, MO 63132

Next Steps

- We will review your form to make sure it's complete. Then we will let you know by mail that we received it.

- We'll let Medicare know you've applied to Stanford Health Care (HMO).

- Within 10 calendar days after Medicare confirms you're eligible, we'll let you know when your coverage starts. Then we'll send you an ID card and welcome packet for new members.

Essence Healthcare is an HMO plan with a Medicare contract. Enrollment in Essence Healthcare depends on contract renewal.

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Section 1 – all fields on this page are required (unless marked optional)			
Please check which plan you want to enroll in: **(Check ONLY one)**	**Stanford Health Care (HMO)** ☐ Platinum ☐ Gold		
Employer or Union Name:			Group #:
Are you a current or former member of any Stanford Health Care health plan (Optional)?			Member ID:
LAST Name:	FIRST Name:	Middle Initial (Optional):	
Birth Date: ____ / ____ / _____ (MM/DD/YYYY)	Sex: ☐ Male ☐ Female	Phone Number (select primary phone number): ☐ Mobile: ( ) ☐ Home: ( )	
Permanent Residence street address (Don't enter a P.O. Box):			County (optional):
City:	State:		ZIP Code:
Mailing Address, if different from your permanent address (PO Box allowed): Street Address			
City:	State:		ZIP Code:
E-mail Address (Optional):			

Your Medicare Information	
Medicare Number:	__ __ __ __- __ __ __ - __ __ __ __

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Will you have other prescription drug coverage (like VA, TRICARE) in addition to Stanford Health Care (HMO)?

☐ 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:
_____	_____	_____

Section 2 – All fields in this section are optional

If your employer provides retiree coverage, are you the retiree? ☐ Yes ☐ No

If "yes", retirement date: _____

If "no", name of retiree: _____ Retirement date: _____

Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No

If "yes", name of spouse: _____

Name of dependent(s): _____

Requested Effective date: _____

Primary Care Physician (PCP):	PCP # from Provider Directory:	Is this your current physician?
Dr. _____ _____ (First Name) (Last Name)	☐☐☐☐☐☐☐☐☐☐	☐ Yes ☐ No

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Select one if you want us to send you information in a language other than English.

☐ Spanish ☐ Korean ☐ Chinese ☐ Tagalog ☐ Vietnamese

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large Print

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Please Read and Sign Below

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

Stanford Health Care (HMO) is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Part B, however some employer groups require both 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. 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. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

Stanford Health Care (HMO) serves a specific service area. If I move out of the area that Stanford Health Care (HMO) 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 Stanford Health Care (HMO), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Stanford Health Care (HMO) 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 Stanford Health Care (HMO) coverage begins, I must get all of my health care from Stanford Health Care (HMO), except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Stanford Health Care (HMO) and other services contained in my Stanford Health Care (HMO) Evidence of Coverage document (also known as a

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member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR STANFORD HEALTH CARE (HMO) 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 Essence Healthcare, he/she may be paid based on my enrollment in Stanford Health Care (HMO).

Release of Information: By joining this Medicare health plan, I acknowledge that Essence Healthcare will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Essence Healthcare 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 from 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: _____

Sales Agent/Office Use Only:

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

Plan ID #: _____ **Agent ID #:** _____

Effective Date of Coverage: _____ **Date Application Rec'd**: _____

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