MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM
EL PASO COUNTY SPONSORED GROUP PLAN

To enroll in Humana® Group MAPD please provide the following information:

Desired Effective Date: _____

LAST Name:	FIRST Name:	MIDDLE Initial:	Mr. Mrs. Ms.

Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: M F	Social Security Number:	Home Phone Number: ( )

Permanent Residence Street Address:

City:	State:	ZIP Code:

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

Email Address:

Phone Number (Optional

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 or Part B (or both) to join a Medicare prescription drug plan.

Name: _____

Medicare Beneficiary Identifier (MBI)

__ __ __ __ - __ __ __ - __ __ __ __

Is Entitled To	Effective Date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

If you have end-stage renal disease (ESRD), please fill this oval. ○ **I have ESRD**

If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, please attach a note or records from your doctor showing you have had a successful kidney transplant, or you don't need dialysis. If you don't attach this information, we may need to request it later, and if not received, your application could be denied.

PLEASE READ THIS IMPORTANT INFORMATION

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

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

The Humana Group Medicare PPO Plan is a Medicare Advantage health plan that has a contract with the Federal government, and I will need to keep my Medicare Parts A and B and must continue to pay my Medicare Part B premium. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform Humana 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. I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. Once I've enrolled in this Humana plan, I can change or cancel my Humana coverage at any time and return to Original Medicare or another Medicare Advantage plan using a special election. However, I may not be eligible to return to the group plan or change plans outside of the group's open enrollment period. I can receive details of my options by calling my plan administrator or customer service.

This Humana plan serves a specific service area. If I move out of the area that this Humana plan serves, I need to notify Humana so I can disenroll and find a new plan in my new area. Once I am a member of Humana, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Humana when I get it to know which rules, I must follow in order to get coverage with this Medicare Advantage plan.

I understand that on the date Humana coverage begins, I must get all of my health care from Humana, except for emergency or urgently needed services or out-of-area dialysis. Services authorized by Humana and other services contained in my Humana Evidence of Coverage will be covered. Without authorization, NEITHER MEDICARE NOR HUMANA WILL PAY FOR THE SERVICES.

I understand that I am enrolling into a Humana Medicare Advantage Plan or a Humana Medicare Prescription Drug Plan and not a Medicare Supplement, Medigap, Medicare Select, or Medicaid plan.

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.

Release of Information:

By joining this Medicare health plan, I acknowledge that Humana will release my information to Medicare and other plans as necessary for treatment, payment and health care operations. I also acknowledge that Humana 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.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Humana the Part D-IRMAA.

Signature:	**Today's Date:**