LACERA

Universal Enrollment Form for Medicare Advantage Prescription Drug Plan (MAPD)

(For those enrolled in Medicare Part A and Part B)

Instructions

To assist you in completing this form, a SAMPLE has been provided on www.lacera.com, under the Retiree Healthcare tab.

Print your name and Social Security number at the top of pages 2 – 6. Please be sure you complete and submit all **six pages** of the form. ***Keep the pink copy for your files***.

Carrier-Required Information

Section 1: Personal Information

- Fill in the personal information requested. If you and your spouse are both enrolling, each must complete a separate form.
- Fill in your Medicare information on the replica of the Medicare card or attach a photocopy of your Medicare card.
- Check the appropriate marital status box.

Section 2: Medical Information

- Please answer the five questions by checking "Yes" or "No" on the right-hand side of the form.
- Answer for member and, if enrolling, for spouse/survivor.

Section 3: Binding Arbitration Agreement

- Carefully read each paragraph in this section.
- **Sign and date the form below the Arbitration Agreement paragraph that applies to your medical plan.** (For UnitedHealthcare, Cigna HealthCare and SCAN Health Plan, sign and date at the bottom of Page 4. For Kaiser Foundation Health Plan, sign and date at the top of Page 5.)
- If someone has assisted you in completing this form, that person must also sign this form and indicate his/her relationship to you.
- If a person with Durable Power of Attorney for Health Care (DPAHC) or another legal representative (as defined by State law) has helped you complete this form, they must sign and attach certificate or other written proof of guardianship.

LACERA-Required Information

Section 4: Medical Plan

- Check the box next to the MAPD plan in which you wish to enroll, and fill in the requested information.
- Next, write in the name and facility number of the contracting medical group or physician that you have selected, where applicable. Refer to your plan's Provider Directory for medical group and physician information.

Section 5: LACERA Authorization

- Carefully read each paragraph and the "Statement of Understanding" that follows. **You must initial the area stating you have read the Statement of Understanding and Authorization to Exchange Information.** Without your initials, this form will be considered incomplete and the start of your coverage may be delayed.
- **Sign the form on the lines provided in this section.** You must print and physically sign this form. LACERA cannot accept electronic signatures at this time.
- If someone has assisted you in completing this form, that person must also sign this form at the very bottom and indicate his/her relationship to you.
- If a person with Durable Power of Attorney for Health Care (DPAHC) or other legal representative (as defined by State law) has helped you complete this form, they must sign and attach certificate or other written proof of guardianship.

Note: The arbitration agreement at the bottom of the "Statement of Understanding" does not pertain to Nevada residents.

LACERA

Los Angeles County Employees Retirement Association

Medicare Advantage Prescription Drug Plan (MAPD) Universal Enrollment/Election Form

(To Be Filled out by LACERA)	Years of Service: _____	Email/Fax Date: _____ PPA: ____
Retirement Date: _____	Current Med: _____	Input Date: _____ Initials: ____
Effective Date: _____	New Med: _____	AME Entry Date: _____
☐ SCD ☐ NSCD ☐ Tier 1 ☐ Tier 2	Premium: _____	Emp Site Entry Date: _____

Please check all that apply:
Completed by:

☐ Retiree Enter retirement date: _____

☐ Spouse/DP Enter name of retiree: _____

☐ Survivor Enter name of retiree: _____

Marital Status:

☐ Single ☐ Married,

☐ Widowed If yes Date of Marriage/

☐ Divorced/ Termed DP DP Registration _____

SECTION 1: Personal Information

Medicare Advantage Prescription Drug (MAPD) plan you are requesting enrollment in:

Employer Group Name **LACERA**	Group#	Requested Effective Date (subject to CMS approval)
Desired Contracting Medical Group (if applicable)	Desired Contracting Physician (if applicable)	Medical Group/Physician No. (if applicable)
Last Name	First Name MI	Gender ☐ M ☐ F
Permanent Residence Address (Street Address Only—No P.O. Box)		
City State		Zip County
Mailing Address if Different (Street, City, State, Zip)		
Daytime Phone Number (including area code)		E-mail address (optional)
Evening Phone Number (including area code)		
Social Security Number (SSN)		Date of Birth

Are you the Subscriber? ☐ Yes ☐ No
If no, provide Subscriber Name and Social Security Number (your group may require this information)

Subscriber Name _____ Subscriber SSN__ __ __-__ __- __ __ __ __

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

Is Entitled To:	Effective Date
HOSPITAL (Part A)	----/----/--------
MEDICAL (Part B)	----/----/--------

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

401- 01/23 6,500 <SKU#958622216 (10/2022)>

DISTRIBUTION: White (Health Plan Copy); Pink (Medicare Beneficiary Copy)

INSM

CONTINUE

Last Name (Print) First Name (Print) M.I. Social Security Number

SECTION 2: Medical Information

1. Are you the retiree? ☐ Yes ☐ No

   If yes, retirement date (month/date/year): _____ /_____ /_____

   If no, name of retiree: _____

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

   If yes, name of spouse: _____

   Name(s) of dependent(s): _____

3. Do you or your spouse work? ☐ Yes ☐ No

4. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or state pharmaceutical assistance programs. Will you have other prescription drug coverage? ☐ Yes ☐ No
   If yes, please list your other coverage and your identification(ID) number(s) for this coverage.

   Name of other coverage: _____

   ID # for coverage: _____

5. 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 of Institution (number and street): _____

   Phone Number of Institution:(_____) _____ - _____

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a, or Spanish origin
☐ Yes, Puerto Rican
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Cuban
☐ **I choose not to answer**

What's your race? Select all that apply.

☐ American Indian or Alaska Native
☐ Asian Indian
☐ Black or African American
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean
☐ Native Hawaiian
☐ Other Asian
☐ Other Pacific Islander
☐ Samoan
☐ Vietnamese
☐ White
☐ **I choose not to answer**

401- 01/23 6,500 <SKU#958622216 (10/2022)>

DISTRIBUTION: White (Health Plan Copy); Pink (Medicare Beneficiary Copy)

CONTINUE

Please contact the health plan if you would prefer to receive information in a language other than English or in another format.

By completing this enrollment application, I agree to the following:
This health plan 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 only be in 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. 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 may leave this plan at any time by sending a request to the health plan or by calling **1-800-MEDICARE** (**1-800-633-4227** or **TTY 1-877-486-2048**), 24 hours a day, 7 days a week. However, before I request disenrollment, I will check with my group or union/trust fund to determine if I am able to continue my group membership.

I understand that if I currently have coverage through more than one employer or union/trust fund, I must choose one of these coverage options for my Medicare Advantage plan because I can be enrolled in only one Medicare Advantage plan at a time. My other employer or union/trust fund may allow me to enroll in one of their non-Medicare plans as well. I will contact the benefit administrators at each of my employers or trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or trust fund's plan to select for my Medicare Advantage plan.

CONTINUE, AND SIGN

REMEMBER: You must provide your signature in Section 3: Binding Arbitration Agreements.

- If enrolling in a UnitedHealthcare, Cigna HealthCare or SCAN Health Plan, sign and date at the bottom of Page 4.
- If enrolling in a Kaiser Foundation Health Plan, sign and date the appropriate signature line on Page 5.

Last Name (Print) First Name (Print) M.I. Social Security Number

I understand that this Medicare Advantage Plan serves a specific service area. If I move out of the area that the Medicare Advantage 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 this Medicare Advantage Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the **Evidence of Coverage** document from the Medicare Advantage Plan 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 the Medicare Advantage Plan coverage begins, I must get all of my health care from this Medicare Advantage Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by this Medicare Advantage Plan and other services contained in my **Evidence of Coverage** document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THIS MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES.**

RELEASE OF INFORMATION:
By joining this Medicare Health Plan, I acknowledge that the Medicare Health Plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that this Medicare 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/election 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.

SECTION 3: Binding Arbitration Agreements

Arbitration Agreement for UnitedHealthcare (UHC), Cigna HealthCare and SCAN Health Plan

I understand that, if I select a health insurance plan ("health plan") that uses mandatory binding arbitration to resolve disputes, I am agreeing to arbitrate claims that relate to my or a dependent's membership in the health plan (except for Small Claims Court cases, claims governed by the ERISA claims regulation, and other claims that cannot be subject to binding arbitration under governing law). I understand that any dispute between myself, my heirs, relatives, or other associated parties on the one hand and the health plan, any contracted health care benefit providers, administrators, or other associated parties on the other hand for alleged violation of any duty arising out of or related to membership in the health plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is in the health plan's coverage document, which is available for my review.

Signature _____ **Date** _____

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

Name _____
(Please print)

Address _____

Phone Number ( ) _____ - _____

Relationship to Enrollee _____

CONTINUE

Last Name (Print) First Name (Print) M.I. Social Security Number

Arbitration Agreement for Kaiser Foundation Health Plan - California

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP , including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Signed _____ Date _____ 20_____

Arbitration Agreement for Kaiser Foundation Health Plan - Hawaii

Except as provided in the Kaiser Foundation Health Plan Hawaii Arbitration Agreement, any and all claims or disputes shall be resolved by binding arbitration. I acknowledge that I have read and understood the information in the Kaiser Foundation Health Plan Hawaii Arbitration Agreement (attached). I, on behalf of myself, all applicants, and family members, hereby agree to binding arbitration and give up our constitutional rights to a jury or court trial.

Signed _____ Date _____ 20_____

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

Name _____
(Please print)

Address _____

Phone Number ( ) _____ - _____

Relationship to Enrollee _____

401- 01/23 6,500 <SKU#958622216 (10/2022)>

DISTRIBUTION: White (Health Plan Copy);
Pink (Medicare Beneficiary Copy)

CONTINUE, INITIAL AND SIGN NEXT PAGE

REMEMBER: You must provide both your initials and signature in Section 5: LACERA Authorization stating you have read the Statement of Understanding and Authorization to Exchange Information. If you submit this form without initialing and signing, this form will be considered incomplete and the start of your coverage may be delayed.

You must physically sign this form. LACERA cannot accept electronic signatures at this time.

(CONTINUE NEXT PAGE)

Last Name (Print) First Name (Print) M.I. Social Security Number

SECTION 4: Medical Plan

I wish to enroll in the following MAPD plan: (Check one and fill in the requested information. Refer to your plan's Provider Directory for physician/medical group selections.)

☐ **Kaiser Permanente Senior Advantage**
Please check the state in which you live: ☐ CA ☐ CO ☐ GA ☐ HI ☐ OR ☐ WA
If you were ever a Kaiser member when you were under age 65, please list your medical record number _____

☐ **Cigna Preferred with Rx (Only in Phoenix, Arizona) (FOR LACERA USE ONLY)**

☐ **UnitedHealthcare Group Medicare Advantage**
If you were ever a UnitedHealthcare member when you were under age 65, please include your member number
Provider preference. Please specify your selection below:

Physician Name_____Number _____

Medical Group _____Number _____

Are you an existing patient? ☐ Yes ☐ No

☐ **SCAN Health Plan**

1. _____ (Initials) I understand that SCAN Health Plan is an MAPD Plan program operating under contracts with CMS. In the event the program is not continued, SCAN Health Plan must assist me in obtaining suitable alternative health care and provision of my Medicare-covered health care will not be interrupted.
2. Please check the state in which you live: ☐ AZ ☐ CA ☐ NV
3. Provider preference. Please specify your selection below:

Physician Name_____ Number_____

SECTION 5: LACERA Authorization

I understand the LACERA Board of Retirement reserves the right to amend, revise or discontinue these plans and programs at any time. I hereby enroll in the MAPD HMO indicated above. I authorize LACERA to make the necessary deductions from my retirement warrants for any contributions required of me and to send these contributions to the MAPD HMO I have chosen.

Please read the information on the back of page 1 and page 2 of this form and initial here before signing. ***If you submit this form without initialing it, this form will be considered incomplete and the start of your coverage may be delayed.***

_____ (Initials)

_____ _____
Your signature or signature of guardian, conservator or power of attorney* Date

**If this is being submitted by a guardian, conservator, or person with power of attorney, please attach the legal documents establishing guardianship, conservatorship or power of attorney.*

If anyone helped you fill out any portion of this form, with the exception of the effective date, please have them sign the following:

_____ _____ _____
Signature Date Relationship to Individual

401- 01/23 6,500 <SKU#958622216 (10/2022)>

DISTRIBUTION: White (Health Plan Copy); Pink (Medicare Beneficiary Copy)

Statement of Understanding

Please read each of the statements that follow before signing this form:

I understand that Medicare Advantage plans are contracted with the Federal government and I will abide by any Health Plan policies and rules that may apply to me.

- Lock-In: I understand that, beginning on the date of my Medicare Advantage Prescription Drug plan coverage begins, I must get all of my health care from/through the Medicare Advantage Prescription Drug plan, with the exception of emergency and out-of-area urgently needed services, dialysis services or authorized referrals. I understand that services authorized by the Medicare Advantage Prescription Drug plan and other services contained in my plan **Evidence of Coverage** document will be covered. I also understand that without authorization neither Medicare nor the Medicare Advantage Prescription Drug plan will pay for the services. As a Medicare Advantage Prescription Drug plan member, I understand that I am bound by the benefits, copayments, exclusions, limitations, and other terms of the Medicare Advantage Prescription Drug plan **Evidence of Coverage**.

- I understand that I will be notified by mail of the final confirmation of my enrollment in the plan and the effective date of my coverage. I understand that I should not disenroll from any supplemental plan until my enrollment is confirmed.

- I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premium and the Part A premium, if applicable.

- I understand that I can be a member of only one Medicare Advantage Prescription Drug plan at a time. By enrolling in the Medicare Advantage Prescription Drug plan specified on this form, I understand that I will be automatically disenrolled from any other Medicare Advantage Prescription Drug plan of which I am currently a member.

- I also understand that since I can be a member of only one Medicare Advantage Prescription Drug plan at a time, I cannot enroll in more than one Medicare Advantage Prescription Drug plan with the same effective date of coverage. If I do this, my enrollments will be canceled and I will have to fill out a new enrollment form to become a member of a Medicare Advantage 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 I may request termination of this Medicare Advantage Prescription Drug plan at any time by sending a written request for disenrollment to the health plan, by calling **1-800-MEDICARE** (**1-800-633-4227**), enrolling in another Medicare Advantage or Part D plan, or electronically disenrolling on the Medicare Advantage Prescription Drug plan's website if it is offered by the Medicare Advantage Prescription Drug plan. Until the effective date of disenrollment, I must continue to receive health care from my current plan providers.

- I understand that if I do not 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 it is my responsibility to inform the Medicare Advantage Prescription Drug plan before permanently moving (for 6 months or longer) out of the service area or a continuation area, if applicable to your plan. I understand that if I move permanently out of the service area or continuation area, Medicare requires the Medicare Advantage Prescription Drug plan to disenroll me.

- I understand that if I disenroll from the LACERA-administered Medicare Advantage Prescription Drug plan, I may be automatically transferred to the Original Medicare plan (fee-for-service program). I understand that if I choose to enroll in a non-LACERA-administered Medicare Advantage Prescription Drug plan, or another employer-sponsored Medicare Advantage Prescription Drug plan, I will be automatically disenrolled from this LACERA-administered health plan.

- I understand that, as a member of the Medicare Advantage Prescription Drug plan, I have the right to appeal service and payment denials made by the plan.

Authorization to Exchange Information

Please read the following statements before you sign this form.

- I hereby authorize the Centers for Medicare & Medicaid Services to furnish information to the health plan confirming my Part A (hospital) and Part B (medical) Medicare entitlement, and if my enrollment is terminated, the effective date of my termination.

- I hereby authorize the health plan, or any holder of medical information about me including, but not limited to, physicians, hospitals, insurance companies, and other organizations, to release any information in the course of examination or treatment of myself, which is relevant to the provision of or the coordination of benefits or professional review activities. I also acknowledge that my health plan may release my information to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this election 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 also authorize the health plan, or any holder of medical information about me including, but not limited to, physicians, hospitals, insurance companies, and other organizations, to release to the Centers for Medicare & Medicaid Services or its intermediaries or carriers, any information needed to administer Title XVIII (the Medicare section) of the Social Security Act.

- Applicable to Arizona plans only: This authorization will be valid for a period not to exceed 30 months past the date of my signature on page 4.

LACERA treats your and your family's personal health information as confidential. We follow the applicable sections of HIPAA related to privacy and security of your protected health information. If you have any questions about the steps taken to secure your protected health information, please refer to the HIPAA policy posted on the LACERA website at www.lacera.com.

IMPORTANT NOTE: You must initial the area in SECTION 5: LACERA Authorization stating you have read the above Statement of Understanding and Authorization to Exchange Information. If you submit this form without initialing it and signing it, this form will be considered incomplete and the start of your coverage may be delayed.