MEDICAL ASSOCIATES

2024 WISCONSIN

☐ Medical Associates SmartPlan (COST) $136.00
☐ Medical Associates Community Plan (COST) $165.00
☐ Medical Associates Freedom Plan (COST) $203.00
**You must continue to pay your Medicare Part B premium.*

NOTE: For more detailed information on coverage, please refer to the Summary of Benefits.

Request Enrollment Effective Date: _____ /01 /24

Last Name	First Name	MI

Birth Date ___ /___ /_____	Gender ☐ Male ☐ Female	E-mail

Street Address	Telephone	☐ Cell ☐ Home

City	County	State	Zip

☐ New to Medicare Part A and/or B ☐ Replacing coverage _____ ☐ Transfer (Member# R_____)

1. **Do you have End Stage Renal Disease (ESRD)?** ..... ☐ Yes ☐ No
   If yes and you do not need regular dialysis anymore or you 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.
2. **Will you or your spouse be working when this plan begins?** ..... ☐ Yes ☐ No
   If "yes," **do you have health coverage through you or your spouse's current or former employer?** ☐ Yes ☐ No
3. **Are you enrolled in your State Medicaid program?** ..... ☐ Yes ☐ No
   If "yes," please provide your Medicaid number: _____

- Fill out this information as it appears on your Medicare card *-OR-*
- Attach a copy of your Medicare card or your letter from the Social Security or the Railroad Retirement Board.

You must have Medicare Part B to join a Medicare Cost Plan.

Name (as it appears on your red, white and blue Medicare card):
_____
Medicare number: _____ - _____ - _____

Entitled to:	Coverage starts:
Hospital (Part A)	_____
Medical (Part B)	_____

I understand that my signature on this application means that I have read and understand the contents of this application (including the reverse side). Please read your Evidence of Coverage (EOC) document to know what rules you must follow in order to receive coverage with this health plan.

Signature: _____ Broker Signature: _____
Date: _____ Date: _____

* If this is being submitted by a legal guardian or Power of Attorney (POA), you must provide the following information below, and attach a copy of the legal document establishing guardianship or POA.

Legal Guardian or POA Full Name: _____ Phone Number: _____ - _____ - _____
Street Address: _____ Relationship to Enrollee: _____
City: _____ State: _____ Zip: _____

ID Card: ☐ Yes ☐ No Handbook: ☐ Yes ☐ No | Send Mail to: ☐ Beneficiary ☐ POA/Legal Guardian

Payment Method: ☐ Automatic Bank Withdrawal ☐ Coupon Book
☐ First month premium collected: Amount: $_____ Check: #_____

Annual Mailing/EOC delivery preference:
☐ Electronic (e-mail) ☐ Printed copy

***** OVER *****

Contact Member Services at 1-866-821-1365 if you need information in an accessible format or language other than what is listed below. Office hours are M-F, 8:00am to 5:00pm, CST. TTY users call 1-800-735-2942.

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:
Other language: ☐ Spanish ☐ Other:_____ Other format: ☐ Audio tape ☐ Large print ☐ Other: _____

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, Mexican, Mexican American, Chicano/a ☐ Yes, Cuban
☐ Yes, Puerto Rican ☐ Yes, another Hispanic, Latino/a, or Spanish origin ☐ **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**

By completing this enrollment application, I agree to the following: Medical Associates Health Plans, Inc. (MAHP) is a Medicare COST plan and I will need to keep my Medicare Part B. I can be in only one Medicare Health plan at a time. I know I may disenroll from this MAHP plan at any time by sending a written request to MAHP or by calling I-800-Medicare (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

I understand that beginning on the date MAHP coverage starts, in order for MAHP to fully cover my medical services (except for emergency or urgently-needed services), all of my health care must be provided or arranged by MAHP. If I obtain services not provided or arranged by MAHP, I will be responsible for all Medicare deductibles and coinsurance, MAHP copayments, as well as any additional charges as prescribed by the Medicare program. I may also be liable for charges not covered by Medicare.

Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico. Services authorized by MAHP and other services contained in my MAHP Evidence of Coverage document will be covered.

Each year MAHP is required to send you the Annual Notice of Changes (ANOC) and Evidence of Coverage (EOC) documents describing the changes to your coverage. You can elect to receive these documents electronically to your personal email address. If you initially select the electronic delivery, you can request the printed materials at any time.

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

I understand that my signature (or the signature of the person authorized to act on my behalf under State law 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 MAHP or by Medicare.

Mailing address: Medical Associates Health Plans (MAHP), 1605 Associates Drive, Suite 101, Dubuque, Iowa 52002

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