Independent Care Health Plan Enrollment Request Form

Please contact Independent Care Health Plan (*i*Care) if you need this information in another language or in an accessible format (Braille).

To Enroll in *i*Care, Please Provide the Following Information

Please check which plan you want to enroll in:

- ☐ *i*Care Medicare Plan (HMO D-SNP) H2237-001
- ☐ Aurora CompleteCare (HMO D-SNP) H2237-009
- ☐ *i*Care Family Care Partnership Plan (HMO D-SNP) H2237-007

LAST name:	FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date: (__ __/__ __/__ __ __ __) (M M /D D/ Y Y Y Y)	Sex: ☐ M ☐ F	Home Phone Number: ( )	Alternate Phone Number: ( )

Permanent Residence Street Address (P.O. Box is not allowed):

City:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):

City:	State:	ZIP Code:

Emergency contact: _____

Phone Number: _____ **Relationship to You:** _____

Email Address:

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 if 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 Part A and Part B to join a Medicare Advantage plan.

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Please Read and Answer These Important Questions

1. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to an *i*Care plan? ☐ 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: _____

3. 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 & Phone Number of Institution (number and street):

_____

4. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If "yes" please provide your Medicaid number: _____

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

6. Please give us the name of your primary care provider (PCP), clinic or health center.

Provider or PCP full name:

Provider or PCP phone number: ( )

7. Do you require plan information in another language other than English or in an accessible format?

☐ Yes ☐ No

Please check what language and/or accessible format you require:

☐ Spanish ☐ Braille ☐ Large Print

☐ Other language or accessible format list here: _____

Please contact *i*Care at 1-800-777-4376 if you need information in an accessible format or language other than what is listed above. Our office hours are Monday – Friday, 8:30 a.m. – 5:00 p.m. TTY users should call 1-800-947-3529.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining *i*Care could affect your employer or union health benefits. You could be disenrolled from your employer or union health coverage if you join *i*Care. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below

By completing this enrollment application, I agree and understand the following:

- This is a Medicare Advantage plan. It has a contract with the Federal government.
- I need to keep my Medicare Parts A and B. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- I can be in only one Medicare Advantage plan at a time. If I'm a member of another Medicare health plan or Prescription Drug plan and I join this plan, I will be disenrolled from the other plan.
- If I have prescription drug coverage now or if I get it from somewhere else later, I will tell *i*Care.
- *i*Care covers a specific service area. If I plan to move out of the area, I will call *i*Care to switch to a plan in the new area. 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 will get an Evidence of Coverage (EOC). (The EOC is also known as a member contract or agreement.) The EOC will list services the plan covers, as well as *i*Care's terms and conditions. *i*Care will cover services it approves, as well as services listed in the EOC. If a service isn't listed in the EOC or approved by *i*Care, Medicare and *i*Care won't pay for it. If I disagree with how *i*Care covers my care, I have the right to make an appeal.
- *i*Care will give my information to Medicare and other plans when needed for treatment, payment and health care operations. This may include my prescription drug information. Medicare uses the information to understand how my care was handled or billed. Other plans may need my information when they help pay for my care. Medicare may also give my information for research and other purposes. All federal laws and rules protecting my privacy will be followed.
- The information on this form is correct to the best of my knowledge. I understand that if I put information on this form that I know is not true, I will be disenrolled from the plan I enroll in.

When I complete this application, it means I have read and understand the information on this form.

If I sign as an authorized representative, it means that I have the legal right under state law to sign. I can show written proof of this right if Medicare asks for it or *i*Care requests it.

Signature of Applicant/Member/Authorized Representative:	Today's date:

If you are the authorized representative, please sign above and complete the information below:		
Last name:	First name:	
Address:		
City:	State:	ZIP Code:
Phone number: ( )	Relationship to Applicant:	

Office Use Only	
Name staff member/agent/broker (if assisted in enrollment):	
Plan ID #:	Effective date of coverage:
ICEP/IEP:	AEP:
SEP (type):	Not eligible:

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

Independent Care Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity, or sex.

Independent Care Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, or sex.

Independent Care Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at 1-800-777-4376 (TTY: 1-800-947-3529), 24 hours a day, 7 days a week (Office hours: Monday – Friday, 8:30 a.m. – 5:00 p.m.).

If you believe that Independent Care Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, gender identity, or sex, you can file a grievance with: QAPI Nurse Jeanne Weiss, 1555 North RiverCenter Drive, Suite 206, Milwaukee, Wisconsin 53212, 1-800-777-4376 (TTY 1-800-947-3529), P: 414-963-5343, F: 414-918-7592; or jweiss@icarehealthplan.org. You can file a grievance in person or by mail, fax, or email.

If you need help filing a grievance the QAPI Nurse Jeanne Weiss is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Multi-language Interpreter Services

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-777-4376 (TTY: 1-800-947-3529).

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-777-4376 (TTY: 1-800-947-3529).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-777-4376 (TTY: 1-800-947-3529).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電。1-800-777-4376 (TTY: 1-800-947-3529).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-777-4376 (TTY: 1-800-947-3529).

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-777-4376 (رقم هاتف الصم والبكم: 1-800-947-3529).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-777-4376 (телетайп: 1-800-947-3529).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-777-4376 (TTY: 1-800-947-3529) 번으로 전화해 주십시오.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-777-4376 (TTY: 1-800-947-3529).

Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-777-4376 (TTY: 1-800-947-3529).

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-777-4376 (TTY: 1-800-947-3529).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-777-4376 (ATS: 1-800-947-3529).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-777-4376 (TTY: 1-800-947-3529).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-777-4376 (TTY: 1-800-947-3529) पर कॉल करें।

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-777-4376 (TTY: 1-800-947-3529).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-777-4376 (TTY: 1-800-947-3529).