GUILDNET SM

MEDICARE ADVANTAGE ENROLLMENT FORM

To Enroll in GUILDNET GOLD, Please Provide the Following Information:

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: *(providing this information is optional)*	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:

Emergency contact:

Contact Phone Number: ( ) - Relationship to You:

Applicant E-mail Address:

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 and Part B to join a Medicare Advantage plan.

SAMPLE ONLY

Name: _____

Medicare Claim Number Sex ___

__ __ __ - __ __ - __ __ __ __ ___

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Please read and answer these important questions:

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

If you answered "yes" to this question and you do not need regular dialysis any more, or 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. 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 GUILDNET GOLD? ☐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 Medicaid? ☐ Yes ☐ No

If yes, please provide your Medicaid number: _____

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

Please choose the name of a Primary Care Physician (PCP), clinic or health center (if required):

PCP Name: _____ ID # : _____

Please check one of the boxes below if you would prefer us to send you information in a language other than English:

☐ Spanish ☐ Russian ☐ Chinese ☐Other _____

Please Read This Important Information

If you currently have health coverage from an employer or union, joining GUILDNET GOLD could affect your employer or union health benefits. If you have health coverage from an employer or union, joining GUILDNET GOLD may change how your current coverage works. 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 is no 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 to the following: GUILDNET GOLD is a Medicare Advantage and Medicaid Advantage Plus plan and I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time. In order to remain enrolled in this plan, I must enroll and stay enrolled in both Medicare Advantage and Medicaid Advantage Plus. 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 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. Enrollment in this plan is voluntary and I may leave at any time by sending a request to GUILDNET GOLD or by calling 1-800-Medicare. TTY users should call 1-877-486-2048, 24 hours a day/7days a week.

GUILDNET GOLD serves a specific service area. If I move out of the area that GUILDNET GOLD 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 GUILDNET GOLD, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage and the Member Handbook when I receive it to know which rules I must follow in order to receive coverage with GUILDNET GOLD. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date GUILDNET GOLD coverage begins, I must get all of my health care from GUILDNET GOLD, with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare while out of the county except for limited coverage in Canada and Mexico. Services authorized by GUILDNET GOLD and other services contained in my GUILDNET GOLD Evidence of Coverage document and Member Handbook (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR GUILDNET 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 GUILDNET GOLD 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 behalf of the individual under the laws of New York State) 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 GUILDNET GOLD or by Medicare.

Your Signature:	**Today's Date:**

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

Name : _____

Address: _____

Phone Number: (_____) _____- _____

Relationship to Enrollee _____

Office Use Only:
Name of staff member (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible___

GUILDNET GOLD MEDICAID ADVANTAGE PLUS

Name:_____

Social Security #_____ Date of Birth: _____

NYS Medicaid # _____ Medicare #: _____

- By signing this enrollment agreement, I agree to obtain all covered health and long term care services, as listed in the member handbook, from or with the approval of GuildNet Gold.
- I have received, read and reviewed a copy of the GuildNet Gold Member Handbook and had the opportunity to ask questions about it. I have received a copy of the provider network list.
- I have met with a GuildNet Gold Intake Case Manager and both the services covered, and my rights and responsibilities as described in the handbook, have been fully explained to me.
- I have been given the opportunity to ask questions. I understand the conditions of enrollment.
- I have been informed of my right to appoint a Health Care Proxy and to document Advanced Directives regarding my health care.
- I agree to follow the rules and regulations of the GuildNet Gold plan. I understand the reason(s) for which I may be involuntarily disenrolled, described in the GuildNet Gold Member Handbook.
- I give my permission to GuildNet Gold to release medical information for my care to network providers, hospitals, physicians, other agencies or persons involved in my care.
- I will allow GuildNet Gold to act as my representative to review my Medicaid eligibility.
- I understand that in order to enroll and remain enrolled in GuildNet Gold, I must have both Medicare Advantage and Medicaid Advantage Plus coverage through GuildNet Gold. Failure to remain enrolled in either program will necessitate my disenrollment from GuildNet Gold. If I lose my Medicaid eligibility, I will lose eligibility for this program. Enrollment is voluntary.
- I understand that my enrollment in GuildNet Gold is voluntary, and it will take effect on the first day of the month after it is approved by New York City's Human Resources Administration. In signing this agreement, I retain the right to disenroll from the plan by following the procedures in the Member Handbook, and understand that I must continue to use GuildNet Gold network providers until the effective date of disenrollment.

_____ _____

Signature of New Member Date

_____ _____

Signature of Person Authorized to sign for Member (if Member is unable to sign) Relationship to Member

_____ _____

Witness Date

It is the policy of GuildNet/JGB Health Facilities Corporation to adhere to state and federal laws which prohibit discrimination based on race, color, creed, sexual preference or national and ethnic origin with regard to admission to any of its programs or services or in any of its policies or practices.