GUILDNET GOLD HMO- POS **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 Evidence of Coverage, from or with the approval of GuildNet Gold.
- I have received, read and reviewed a copy of the GuildNet Gold Evidence of Coverage 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 Evidence of Coverage, 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 Evidence of Coverage.
- 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 Evidence of Coverage, 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.