

# MEDICARE ADVANTAGE ENROLLMENT/ELECTION FORM FOR HEALTH NET/SENIORITY PLUS

UBEN 125 (R5/17) University of California Human Resources

Mail second copy to: RASC  
 P.O. Box 24570  
 Oakland, CA 94623-1570  
 OR fax to: 510-465-9037

This Enrollment/Election Form has been sent to you because you or an eligible family member has enrolled in Health Net/Seniority Plus, a Medicare Advantage plan which requires you to assign your Medicare to your plan. Please print clearly using a blue or black ballpoint pen. **Each person on Medicare must complete a separate form.**

- “Subscriber” means the University of California retiree who is carrying the medical insurance through UC.
- “Requested Effective Date” is the first of **the month after your plan receives the signed and completed form** and no earlier than the month the person becomes eligible for and enrolls in Medicare Parts A and B. (Forms submitted 90 days or more before the Medicare Part B Effective Date will be denied.)

Read the entire agreement before you sign the form.

**Top copy**—send to plan: Health Net/Seniority Plus  
 Attn: Enrollment Services  
 P.O. Box 10420  
 Van Nuys, CA 91499-6208

**Second copy**—send or fax to UC at address/fax above.

**Third copy**—keep for your records.

For help with this form, call the UC Retirement Administration Service Center (1-800-888-8267) or your location’s Health Care Facilitator; for the contact list, visit: [ucnet.universityofcalifornia.edu/contacts/health-care-facilitators.html](http://ucnet.universityofcalifornia.edu/contacts/health-care-facilitators.html)

FORM QUESTION	WHAT TO ENTER
Requested Effective Date	If you leave the date blank, your plan will assign the first of the month you are eligible for and enrolled in Medicare, and that they are in receipt of this completed form.
Desired Contracting Medical Group	Enter your medical group (e.g., Hill Physicians, UCSD Healthcare). Check your plan’s website or call to ensure your group and specialists are contracted with Medicare and your plan. <b>This is very important.</b>
Desired Contracting Physician	Enter your primary care physician. Check with your doctor to make sure he/she is contracted with Medicare for your plan. <b>This is very important.</b>
Medical Group/Physician No.	Input if known. If not, leave blank.
Last Name, First Name, MI	Name of the person enrolling. If spouse, enter spouse’s name.
Permanent Residence Address, City, State, Zip	Address of enrollee. No P.O. Boxes accepted—need street address.
Social Security Number (SSN) and Date of Birth	Enter SSN and birthdate for enrollee.
Are you the Subscriber?	Answer Yes, if the enrollee is the UC retiree/survivor. No, if not.
Subscriber’s Name and SSN	Enter the UC retiree’s full name and SSN. <b>This is very important.</b>
Medicare Card	Enter all numbers, letters and dates from enrollee’s Social Security award letter, <b>red/white/blue</b> Medicare card <b>OR send a copy of the card to UC. This is very important.</b>
Question 2 Are you covering a spouse or dependent?	Answer Yes if enrollee is the UC retiree/survivor and is covering family members.
Question 3 Do you or your spouse work?	Answer Yes if enrollee or UC retiree is employed and eligible for any health insurance benefits elsewhere as an employee.
Question 5 Have other drug coverage?	Answer Yes if enrollee has another non-UC prescription drug plan, separate from UC insurance. No, if none.
Signature and Date	Enrollee must sign and date here. <b>This is very important.</b>
Authorized Representative’s Signature plus Name, Address, Phone, Relationship to enrollee	If the enrollee did not sign, the person legally responsible to sign for him/her should sign and date here. <b>This is very important.</b>

**Your medical plan and UC must both receive this form before your Medicare Advantage coverage and any Part B reimbursements can begin.**

Medicare Advantage Plan you are requesting enrollment in:  
**HEALTH NET SENIORITY PLUS**

Employer Group Name (required) <b>University of California</b>	Group # (Plan to complete)	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 Sex <input type="checkbox"/> M <input type="checkbox"/> 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 \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

**MEDICARE HEALTH INSURANCE CARD INFORMATION**

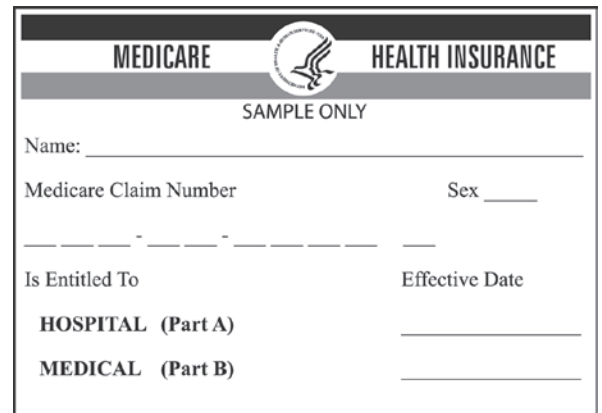
Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

AND/OR—

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

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



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 of dependents: \_\_\_\_\_

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3. Do you or your spouse work?  Yes  No

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4. 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.

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5. 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: \_\_\_\_\_

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6. 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: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

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**Please contact your health plan if you would prefer to receive information in a language other than English or in another format.** Health Net 1-800-539-4072 (TTY 711), 7 days per week, 8 a.m.–8 p.m.

**By completing this enrollment application, I agree to the following:** The health plan I choose (Health Net) 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.

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 any 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 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.

All benefits offered under this Medicare health plan, including optional supplemental benefits, are subject to the Medicare appeals procedures and are not subject to arbitration. Conversely, all other claims including, but not limited to, the following claims, regardless of how they are characterized, are subject to arbitration: Determinations on items or services purchased by my employer, over and above the Medicare approved benefit package, such as payments of premiums or beneficiary cost sharing provided by my employer, any disputes 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 that is not subject to the Medicare appeals process, including any claim for medical or hospital malpractice (a claim that medical services were unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the 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. By signing below, I agree to give up our right to a jury trial and accept the use of binding arbitration for claims that are not subject to the Medicare appeals procedures. 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: \_\_\_\_\_ Date \_\_\_\_\_

Name: \_\_\_\_\_  
(please print)

Address: \_\_\_\_\_

Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Relationship to Enrollee: \_\_\_\_\_

Health Net complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

**Health Net:**

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

If you need these services, contact Health Net's Customer Contact Center at 1-800-275-4737 (TTY: 711), 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center 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, (TDD: 1-800-537-7697).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>