

SENIORS CHOICE ENROLLMENT CHECKLIST

For New Sponsoring Entity

Required paperwork:


- Employer Trust Agreement
- Supporting Business Entity Documentation (Depending on Entity Type - See Trust Agreement)

For New Enrollee


Required paperwork:

- Enrollment Application
- Copies of Medicare card for each enrollee (and spouse, if applicable)
- First month premium check made payable to: "Seniors Choice"

Send enrollment materials to:



**Northwest Marketing Resources, Inc.
PO Box 447
Olympia, WA 98507
800.565.0313
Fax - 360.754.1931**



Entity - Employer Information:

Entity Name: _____
 Address: _____
 City, State, Zip: _____
 County: _____ Phone #: (____) _____
 Executive Contact: _____
 Email Address: _____
 Entity Status: Active Inactive Entity Inception Date: _____
 Entity Closure Date: _____ Not Applicable
 Entity Type: Proprietorship (Schedule C or Occ. License) Corporation (Business License)
 Government (Letter) Partnership / LLC (Form 1065)
 Union (Letter) Non-Profit / Religious (Letter)

All applying entities must attach the requested letter or document when initially applying for coverage.

Seniors Choice Plan Selection and Coverage Information:

Requested Effective Date (1st day of the Month): _____
 Total Number of Full-Time Employees: _____ Total Number of Part-Time Employees: _____
 Total Number of Retirees Over Age 65 with Medicare Parts A and B: _____
 Have You Employed 20 or More Full or Part-Time Employees Yes No
 20 or More Weeks in the Current or Previous Calendar Year?

Medical Plan Selection:

If a \$0 deductible is offered, the sponsoring entity can only offer 2 deductibles (\$0 and \$500). If the sponsoring entity does not offer the \$0 deductible plan option, then they can offer up to 3, with a minimum deductible of \$250 and at least \$500 between each selection.
 Example: \$250/\$750/\$1500.

- | | | |
|--|---|---|
| <input type="checkbox"/> \$0 Deductible Plan | <input type="checkbox"/> \$500 Deductible Plan | <input type="checkbox"/> \$2000 Deductible Plan |
| <input type="checkbox"/> \$100 Deductible Plan | <input type="checkbox"/> \$750 Deductible Plan | <input type="checkbox"/> \$2500 Deductible Plan |
| <input type="checkbox"/> \$150 Deductible Plan | <input type="checkbox"/> \$1000 Deductible Plan | <input type="checkbox"/> \$3000 Deductible Plan |
| <input type="checkbox"/> \$250 Deductible Plan | <input type="checkbox"/> \$1500 Deductible Plan | <input type="checkbox"/> \$4000 Deductible Plan |

Optional Benefit Plan Selection: (If selected, all members must participate)

- Private Duty Nursing Comprehensive Wellness
 At Home Recovery Skilled Nursing Coverage (101 to 365 days per Calendar Year)

Seniors Choice Prescription Drug Plan Election: (Select one or more plans)

- SC Choice Prescription Drug Plan SC Preferred Prescription Drug Plan Premier Prescription Drug Plan

Remittance:

The execution of this agreement does not imply financial responsibility to the Entity / Employer unless elected by same.
 Who should be billed for this coverage? The Entity / Employer The Enrollee / Member

Premium Contribution:

If the Enrollee / Member contributes to the premium, enter the amount or percentage of the premium contribution.

Medical Plan	% _____	or \$ _____	Medical Plan	% _____	or \$ _____
Rx Plan	% _____	or \$ _____	Rx Plan	% _____	or \$ _____

Current Group Medical Coverage:

List any group medical coverage you are currently offering your employees, retirees or members.

Insurer Name: _____
 Policy Number: _____
 Type of Coverage: _____
 Effective Date: _____

Entity - Employer Endorsement:

Please note: This application is subject to approval by MBA, Inc. Do not cancel existing coverage until approved in writing by MBA, Inc.

Signature of Sponsor: _____
 Title of Sponsor: _____
 Name of Sponsor: _____
 Date: _____
 Authority of Sponsor: Owner Corporate Officer Board Member
 Trustee Legal Counsel Human Resources

Agent and General Agent Information:

Agency Name: _____ GA Agency Name: _____
 Agency Street Address: _____ GA Telephone #: _____
 Agency City, State and Zip: _____ GA Fax Number: _____
 Agency Telephone Number: _____
 Agency Email Address: _____
 Agency Tax ID: _____
 Agent Name: _____
 Agent SSN: _____
 Agent Fax Number: _____
 Agent Status: New Appointment Existing Agent
 Commissions Paid To: Agent Agency

Stamp

Administrative Purposes Only:

CMA: Yes No % _____
 DRP: Yes No Member Deductible: _____ Plan Deductible: _____
 CPR: Yes No
 Approved By: _____
 Approved Effective Date: _____
 Group Number: _____ SE Location Number: _____
 Location Number: _____ Rating Area: _____
 Approved Date: _____ Date Stamp: _____

Enrollee Information:

(Attach a copy of Medicare ID Card)

Member Name: _____
 First MI Last

Sex: Male Female

Street Address: _____

City, State, Zip: _____

Medicare Claim # (HIC#): _____ SSN #: _____ / _____ / _____

Sponsoring Entity Name: _____

Telephone #: (____) _____ Date of Birth: _____ / _____ / _____

Are you currently employed: No By your Sponsoring Entity By Another Employer FT PT

Are you currently covered under any employer / union provided group medical plan,

Medicare Supplement Plan or Medicare Advantage Plan?: Yes No

If yes, in order to be eligible for Seniors Choice you must terminate this coverage on or before the requested effective date.

Are you currently enrolled in a Prescription Drug Plan?: Yes No

If "Yes", Plan Type: Medicare Part D Medicare Advantage Employer/Union Group Plan Discount Drug Plan

If "Yes", Plan Name: _____ Carrier Name: _____

Medical Plan Selection: *(You will only be enrolled in a Medical Plan that has been elected by your sponsoring entity)*

- | | | |
|--|---|---|
| <input type="checkbox"/> \$0 Deductible Plan | <input type="checkbox"/> \$500 Deductible Plan | <input type="checkbox"/> \$2000 Deductible Plan |
| <input type="checkbox"/> \$100 Deductible Plan | <input type="checkbox"/> \$750 Deductible Plan | <input type="checkbox"/> \$2500 Deductible Plan |
| <input type="checkbox"/> \$150 Deductible Plan | <input type="checkbox"/> \$1000 Deductible Plan | <input type="checkbox"/> \$3000 Deductible Plan |
| <input type="checkbox"/> \$250 Deductible Plan | <input type="checkbox"/> \$1500 Deductible Plan | <input type="checkbox"/> \$4000 Deductible Plan |

Prescription Plan Election: *(You will only be enrolled in a Prescription Plan that has been elected by your sponsoring entity)*

- SC Choice Prescription Drug Plan SC Preferred Prescription Drug Plan SC Premier Prescription Drug Plan

Spouse/Domestic Partner Information:

(Attach a copy of Medicare ID Card)

Member Name: _____
 First MI Last

Sex: Male Female

Street Address: _____

City, State, Zip: _____

Medicare Claim # (HIC#): _____ SSN #: _____ / _____ / _____

Telephone #: (____) _____ Date of Birth: _____ / _____ / _____

Are you currently employed: No By your Sponsoring Entity By Another Employer FT PT

Are you currently covered under any employer / union provided group medical plan,

Medicare Supplement Plan or Medicare Advantage Plan?: Yes No

If yes, in order to be eligible for Seniors Choice you must terminate this coverage on or before the requested effective date.

Are you currently enrolled in a Medicare Advantage Prescription Drug or Part D Plan?: Yes No

If "Yes", Plan Type: Medicare Part D Medicare Advantage Employer/Union Group Plan Discount Drug Plan

If "Yes", Plan Name: _____ Carrier Name: _____

Medical Plan Selection: *(You will only be enrolled in a Medical Plan that has been elected by your sponsoring entity)*

- | | | |
|--|---|---|
| <input type="checkbox"/> \$0 Deductible Plan | <input type="checkbox"/> \$500 Deductible Plan | <input type="checkbox"/> \$2000 Deductible Plan |
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Prescription Plan Election: *(You will only be enrolled in a Prescription Plan that has been elected by your sponsoring entity)*

- SC Choice Prescription Drug Plan SC Preferred Prescription Drug Plan SC Premier Prescription Drug Plan

Terms and Conditions of Enrollment:

Seniors Choice is not a Medicare Supplement Plan. Seniors Choice is an Employer Group Retiree Medical Plan that coordinates with Medicare. You must be age 65 or over and be enrolled in Medicare Parts A & B to participate in this program. If you have a Medicare Supplement plan, you may not need both the Medicare Supplement plan and the Seniors Choice Employer Group Retiree Program.

On behalf of myself, and my eligible Dependents, I am requesting enrollment under the Senior Choice Plans offered through my former (or current TEFRA eligible) employer. By signing this enrollment application, I agree to and understand the following:

- 1) Medical Coverage:** Subject to the terms and conditions of the GTL Master Policy.
- 2) Medical Coverage:** GTL or its designee shall have access to and use of my and my dependents medical records for purposes of utilization review, processing claims, financial audit or other purposes reasonably related to the performance of this Enrollment Form.
- 3) Medical Coverage:** Do not cancel existing medical coverage until approved in writing by MBA, Inc. During the time that you are covered by an employer's health plan that is primary to Medicare, the Seniors Choice plan will not provide coverage.
- 4) Prescription Coverage:** Is offered by Medco Containment Life Insurance Company. The Medicare Prescription Drug Coverage is administered by Medco Medicare Prescription Plan which is a creditable Part D Plan as governed by CMS.
- 5) Prescription Coverage:** By joining this Medicare prescription drug plan, I acknowledge that Medco Medicare Prescription Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Medco Medicare Prescription Plan will release my information, including my prescription drug event date, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.
- 6) The Seniors Choice Prescription Drug Plan** is a Medicare drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform the Seniors Choice Prescription Drug Plan of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time. If I am currently in a Medicare prescription drug plan, my enrollment in the Seniors Choice Prescription Drug Plan will end that enrollment. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to:
The Seniors Choice Prescription Drug Plan or by calling 1-800-Medicare, 24 hours per day, 7 days per week.
TTY users should call 1-877-486-2048. Final approval of the effective date of enrollment is determined by CMS.
- 7) Prescription Coverage:** I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.
- 8) Prescription Coverage:** Once I am a member of Medco Medicare Prescription 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 Medco Medicare Prescription Plan when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.
- 9)** 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.
- 10)** I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) 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 the Seniors Choice Prescription Drug Plan or by Medicare.
- 11)** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- 12)** A retiree or the dependent spouse or domestic partner of a retiree must: (a) be age 65 or older, (b) be covered under Medicare Parts A and B, (c) not be eligible for Medicaid, (d) not be covered under a Medicare Supplement policy or certificate, (e) not be covered by an employer's health plan which is primary to Medicare due to employment of such person, and (f) not be confined to a Hospital or Skilled Nursing Home on the effective date of coverage. If a retiree or dependent spouse is confined to a Hospital or Skilled Nursing home on the effective date of coverage, coverage will be delayed until the day after the date of release from the Hospital or Skilled Nursing Home.

Member Signature: _____ Date: _____

Spouse / Domestic Partner Signature: _____ Date: _____

Medical Coverage Underwritten by:
Guarantee Trust Life Insurance Company

Administered by:
Gilsbar, Inc.

Prescription Coverage Underwritten by:
Medco Containment Life Insurance Company

For more information, contact Seniors Choice at 1-800-800-6543 or visit www.seniorschoiceplan.com.