

**OFFICE USE ONLY**  
 Group # \_\_\_\_\_  
 EV Status \_\_\_\_\_  
 Effective Date \_\_\_\_\_  
 Disenroll Date \_\_\_\_\_

**INDIVIDUAL ENROLLMENT  
 NON-GROUP ELECTION FORM**



**A AmeriHealth 65 Basic enrollment information. Your Primary Care Physician selection must be made from the AmeriHealth 65 Basic Physician Directory.**

Please PRINT your name and address below:

Name	Social Security No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"><input type="text"/><input type="text"/><input type="text"><input type="text"/><input type="text"/></input></input>	
Address	County	Home Phone (     )
City, State & Zip	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Care Physician (check box if current physician) <input type="checkbox"/>	E-mail Address	
Desired Effective Date	Physician Code No. The 10-digit number beneath provider name in directory <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"><input type="text"><input type="text"/></input></input>	

**B Please enroll me in one of the following: Monthly Premium      C Please answer the following questions:**

**The AmeriHealth 65 Basic Plan (with Rx Option I)**

You must be enrolled with the state and federally funded Medical Assistance program (including Healthy Horizons) and have either a Medicaid access card or Medicaid HMO card to join this plan.

**Are you ... Subscriber (circle)**

• Medicaid eligible?..... Yes No  
If yes, give Medicaid number \_\_\_\_\_

• Residing in a Nursing Home? .... Yes No

• Converting from other AmeriHealth HMO, Inc. coverage?..... Yes No

*You cannot be denied enrollment if you answer yes to any of the above questions.*

• Suffering from End-Stage Renal Disease?..... Yes No  
(ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive)

**D Other Insurance      E Copy this information directly from your Medicare card**

**Current Health Insurance**  
(Take information from your ID card.)

Insurance Company Name: \_\_\_\_\_

Insurance Company ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

**Are you or your spouse employed?**  
Yes  No

Name of Company/ies: \_\_\_\_\_

**Current Prescription Drug Coverage**  
(Take information from your ID card.)

Insurance Company Name: \_\_\_\_\_

Insurance Company ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

**Check if you have:**  
PACE  PACENET

**Health Insurance**

**SOCIAL SECURITY ACT**

CLAIM NUMBER  
 -  -  -

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL INSURANCE PART A  -  -

MEDICAL INSURANCE PART B  -  -

**F Emergency Information**

Please print the name and telephone number of the closest relative or friend to be contacted in case of emergency.

Name \_\_\_\_\_ Telephone \_\_\_\_\_

**G IMPORTANT: Read back of Enrollment Form and sign below**

If anyone helped you fill out this form, he or she must sign below:

Signature \_\_\_\_\_

Date \_\_\_\_\_ Relationship to Beneficiary \_\_\_\_\_

**H IMPORTANT: Read back of Enrollment Form and sign below**

I have read and understand the information on the back of this form.  \_\_\_\_\_

Signature (Beneficiary or Authorized Representative)† \_\_\_\_\_ Date \_\_\_\_\_

†Authorized Representative must provide supporting documentation; for example, copy of durable power of attorney papers.  
**Please keep the GOLD copy of this Enrollment Form as temporary ID, valid for 90 days from enrollment date.**

**STOP**  
**PLEASE READ THIS IMPORTANT INFORMATION**

If you currently have health coverage from an employer or union, joining AmeriHealth 65 Basic could affect your employer or union health benefits. If you have health coverage from an employer or union, joining AmeriHealth 65 Basic 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.

**By completing this enrollment application, I agree to the following:**

- AmeriHealth 65 Basic is a Medicare Advantage plan with a Medicare contract and I will need to keep my Parts A and B and continue to pay applicable premiums. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Since I am eligible for Medicare and Medicaid, I can leave the plan at any time by sending a written request to AmeriHealth 65 Basic, the Social Security Office or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.
- AmeriHealth 65 Basic serves a specific service area. If I move out of the area that AmeriHealth 65 Basic serves, I need to notify the plan so I can disenroll effective the first of the following month and find a new plan in my new area. Once I am a member of AmeriHealth 65 Basic, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from AmeriHealth 65 Basic when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.
- I understand that beginning on the date AmeriHealth 65 Basic coverage begins, I must get all of my health care from AmeriHealth 65 Basic contracted providers, with the exception of emergency or urgently needed services or out-of-area dialysis services within the United States. Medicare beneficiaries are generally not covered under Medicare or AmeriHealth 65 Basic while out of the country except for limited coverage in Canada and Mexico. Services authorized by AmeriHealth 65 Basic and other services contained in my AmeriHealth 65 Basic Evidence of Coverage document will be covered. Without authorization, **NEITHER MEDICARE NOR AMERIHEALTH 65 BASIC WILL PAY FOR SERVICES.**
- I understand that the benefits outlined in the AmeriHealth 65 Basic Summary of Benefits and the AmeriHealth 65 Basic marketing materials are only a summary. A full explanation of my benefits is detailed in the Member Evidence of Coverage.
- AmeriHealth 65 Basic will send me final confirmation of my enrollment. I understand that I should not disenroll from any Medicare supplemental plan or Medigap/Medicare Select plan until I receive confirmation of my enrollment from AmeriHealth 65 Basic.
- I understand that I can be a member of only one Medicare Advantage plan at a time. By enrolling in AmeriHealth 65 Basic, I will automatically be disenrolled from any other Medicare Advantage plan of which I am currently a member. By enrolling in AmeriHealth 65 Basic, I must receive my Medicare Part D prescription drug benefit through this plan. I understand that Medigap insurance or other supplemental insurance is no longer necessary.
- Benefits, premiums and cost sharing may change January 1, 2008.
- If I have special needs, this document may be available in other formats.

Release of Information: By joining this Medicare health plan, I acknowledge that AmeriHealth 65 Basic will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. 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 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 attached to this application and will be available by AmeriHealth 65 Basic and me.

Benefits underwritten or administered by AmeriHealth HMO, Inc.