

## Short Enrollment Request Form

<b>Name of Plan You are Enrolling In:</b>			
<b>Name:</b>		<b>Medicare Number:</b>	
		(Note: may use "member number" instead of "Medicare number")	
Home Phone Number:			
Permanent Street Address: <i>(P.O. Box is not allowed)</i>			
City:		State:	ZIP Code:
<b>Mailing Address:</b> (only if different from your Permanent Street Address)			
<b>Street Address:</b>	<b>City:</b>	<b>State:</b>	<b>ZIP Code:</b>
<b>Please fill out the following:</b>			
I am currently a member of the _____ plan in _____ Piedmont Community HealthCare with a monthly premium of \$ _____.			
I would like to change to the _____ plan in _____ Piedmont Community HealthCare. I understand that this plan has different health benefits and a monthly premium of \$ _____.			
<b>Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:</b>			
<input type="checkbox"/> Spanish			
<input type="checkbox"/> Large Print			
Please contact Piedmont Select Medicare Option One (PPO)/Piedmont Select Medicare Option Two (PPO) at 434-947-3671 or toll-free at 1-877-210-1719 if you need information in another format or language than what is listed above. Our office hours are 8:00 A.M. to 8:00 P.M., seven days a week during the time period of October 15 through February 14. From February 15 until the following Annual Election Period, Customer Service is available 8:00 A.M. to 8:00 P.M., Monday through Friday. TTY users should call 1-877-295-1454.			

### Your Plan Premium

**You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month.**

**If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board. DO NOT pay Piedmont Select Medicare Option One/Piedmont Select Medicare Option Two the Part D-IRMAA.**

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at [www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.gov/prescriptionhelp).

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

**Please select a premium payment option:**

- Get a bill
- Automatic deduction from your monthly Social Security or RRB benefit check. (The Social Security deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)



**Please Read This Important Information**

**Please Read and Sign Below:**

Piedmont Community HealthCare is a plan that has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Piedmont Select Medicare Option One/Piedmont Select Medicare Option Two, he/she may be paid based on my enrollment in Piedmont Select Medicare Option One/Piedmont Select Medicare Option Two.

**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 Piedmont Select Medicare Option One/Piedmont Select Medicare Option Two 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 people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Piedmont Select Medicare Option One/Piedmont Select Medicare Option Two coverage begins, I must get all of my health care from Piedmont Select Medicare Option One/Piedmont Select Medicare Option Two, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Piedmont Select Medicare Option One/Piedmont Select Medicare Option Two and other services contained in my Piedmont Select Medicare Option One/Piedmont Select Medicare Option Two Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR Piedmont Select**

**Medicare Option One/Piedmont Select Medicare Option Two WILL PAY FOR THE SERVICES.**

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where 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.

**Signature:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

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

**Name:** \_\_\_\_\_

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

**Phone Number:** ( \_\_\_\_ ) \_\_\_\_\_

**Relationship to Enrollee** \_\_\_\_\_

**Office Use Only:**

Name of staff member/agent/broker (if assisted in enrollment): \_\_\_\_\_

Plan ID #: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

ICEP/IEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP (type): \_\_\_\_\_ Not Eligible: \_\_\_\_\_