ADVANTAGE MD
Johns Hopkins Medicine Medicare Plan

Mail applications to: Advantage MD Group Enrollment
7231 Parkway Drive, Ste. 100 Hanover MD 21076
Attn: Operations Department
Phone: 1-800-970-0499 (TTY 711) • Fax: 1-410-424-4994

Please contact Advantage MD if you need information in another language or format (Braille).

To Enroll in Johns Hopkins Advantage MD Group, Please Provide the following Information:

Employer Name:				*Advantage MD use only:* Group ID: ☐0001 ☐ 0002	
Johns Hopkins Advantage MD Group (PPO) $175 per month					
LAST name:	FIRST Name:		Middle Initial	Ms. ☐ Mr. ☐ Mrs. ☐	
Birth Date: (__ __/____/_ _ _ _) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Home Phone Number: ( )			*Optional*: Alternate Phone Number:
Permanent Residence Street Address (P.O. Box is not allowed):					
City:	*Optional:* County:			State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address): Street Address: City: State: ZIP Code:					
Optional: **E-mail Address:**					

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card. - OR – • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card): ______________________________ Medicare Number: ______________________ Is Entitled to: Effective Date: HOSPITAL (Part A) ______________________ MEDICAL (Part B) ______________________ You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the So-cial 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 RRB. DO NOT pay Johns Hopkins Advantage MD PPO the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsur-ance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible 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.If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. 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 monthly bill

☐ Electronic funds transfer (EFT) from your bank account each month.

Please enclose a VOIDED check or provide the following:

Account holder name: ________________________

Bank routing number: ________________________

Bank account number: ________________________

Account type: ☐Checking ☐Savings

☐Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐Social Security ☐RRB

The Social Security/RRB 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.

Johns Hopkins Advantage MD is a Medicare Advantage Plan with a Medicare contract offering HMO and PPO products. Enrollment in Johns Hopkins Advantage MD HMO or PPO depends on contract renewal. Out-of-network/non-contracted providers are under no obligation to treat Johns Hopkins Advantage MD members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am retiree or the spouse/domestic partner/dependent of a retiree.
- ☐ I am new to Medicare.
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) ______________________ .
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) ______________________ .
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) ______________________ .
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home). I moved/will move into/out of the facility on (insert date) ______________________ .
- ☐ I recently left a PACE program on (insert date) ______________________ .
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) ______________________ .
- ☐ I am leaving employer or union coverage on (insert date)______________________ .
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a Special Needs Plan (SNP), but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) ______________________ .
- ☐ I moved to a new address that's still in my plan's service area, but I have new plan options in my new location.
- ☐ I was released from jail.
- ☐ I had drug coverage through a Medicare Cost Plan and I left the plan.
- ☐ Medicare is taking an official action (called a "sanction") because of a problem with the plan that affects me.
- ☐ My Medicare Advantage Plan, Medicare Prescription Drug Plan, or Medicare Cost Plan's contract with Medicare wasn't renewed.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date)

If none of these statements applies to you or you're not sure, please contact Johns Hopkins Advantage MD at 1-800-735-0898 (TTY users should call 711) to see if you are eligible to enroll. Oct. 1 through Feb. 14 - Monday through Sunday, 8 a.m. to 8 p.m. Feb. 15 through Sept. 30 - Monday through Friday, 8 a.m. to 8 p.m. On weekends and holidays you will need to leave a message.

Please read and answer these important questions

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 or union plan? ☐ Yes ☐ No

If yes, name of spouse: ____________________________________

Name(s) of dependent(s): ____________________________________

3. Do you or your spouse work? ☐ Yes ☐ No

4. 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 in addition to Advantage MD Group? ☐ 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: _________________________

5. 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 & Phone Number of Institution (number and street):____________________

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer.**

What's your race? Select all that apply:

- ☐ American Indian or Alaska Native
- ☐ Chinese
- ☐ Japanese
- ☐ Other Asian
- ☐ Vietnamese
- ☐ Asian Indian
- ☐ Filipino
- ☐ Korean
- ☐ Other Pacific Island
- ☐ White
- ☐ Black or African American
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ **I choose not to answer.**

Please Choose a Primary Care Physician (PCP), clinic or health center:

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format:

____ Spanish

____ Braille, audio tape, or large print

Please contact Johns Hopkins Advantage MD at 1-877-293-5325 if you need information in an accessible format or language other than what is listed above. Our office hours are, 8 a.m. – 8 p.m., 7 days a week from October 1st to March 30th. TTY users should call 711.

Please Read and Sign Below

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

Johns Hopkins Advantage MD Group 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. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

Johns Hopkins Advantage MD Group serves a specific service area. If I move out of the area that Advantage MD Group 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 Advantage MD Group, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of Coverage document] from Advantage MD Group 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 Advantage MD Group coverage begins, I must get all of my health care from Advantage MD Group, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Advantage MD Group and other services contained in my Advantage MD Group Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR Advantage MD Group WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Advantage MD Group, he/she may be paid based on my enrollment in Advantage MD Group.

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 Advantage MD Group 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 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 ____________________

Agent Use Only:
Name of staff agent (if assisted in enrollment):___________________________
Agent Code:_________________________ FMO Name: ____________________________
Effective Date of Coverage: ___________________
ICEP/IEP: ______ AEP: _______ SEP (type): _____ Not Eligible: ______ Date: _________