brand new day
Health Maintenance Organization

Individual Enrollment Form

To enroll please provide all of the information requested

❑ Mr. ❑ Mrs. ❑ Ms.	First Name:	MI:	Last Name:

Birth Date: (MM/DD/YYYY)	Sex: ❑ M ❑ F	

Permanent Residence Street Address:	Apt # or Space:

City:	State:	Zip Code:	Phone Number:

E-mail address:

Mailing address (only if different than Permanent Residence Address):	Apt # or Space:

City:	State:	Zip Code:	Phone Number:

Alternative contact name: (optional)	Alternative contact E-mail address: (optional)

Alternative Phone Number: (optional)	Relationship to you: (optional) ❑ Friend ❑ Relative ❑ Caregiver ❑ Other ____________

Please check one of the boxes below if you would prefer us to send you information in a language other than English

❑ Spanish ❑ Vietnamese ❑ Chinese ❑ Other

PART 2: PLEASE PROVIDE YOUR MEDICARE INSURANCE 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.

-OR-

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

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

MEDICARE HEALTH INSURANCE
1-800-MEDICARE (1-800-633-4227)
SAMPLE ONLY

Name:________________________________ Sex _____

Medicare Claim Number __ __ __ - __ __ - __ __ __ __ - __

Is Entitled To Effective Date

HOSPITAL (Part A) ____________________________

MEDICAL (Part B) ____________________________

PART 3: YOUR PLAN PREMIUM OPTION

You can pay your plan directly, or have the monthly premium automatically deducted from your Social Security check. If you choose to pay directly, you can pay by mail or by Electronic Funds Transfer (EFT). Generally you must stay with the option you choose for the rest of the year.

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 co-insurance. 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 on line at www.socialsecurity.gov/prescription help.

If you qualify for extra help with your 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 bill

❑ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: ______________________________ Account type: ❑ Checking ❑ Saving

Bank routing number: ______________________________ Bank account number: ________________

❑ Credit Card. Please provide the following information:

Type of Card: ______________________________

Name of Account holder as it appears on card: ______________________________

Account number: ______________________________ Expiration Date: _ _/_ _ _ _ (MM/YYYY)

❑ Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

PART 4: PLAN & PROVIDER INFORMATION:

Effective Date of Coverage: (Note- In general, you may not choose your effective date of coverage. Brand New Day (the "Plan") will let you know when you may begin using plan services):

Please check which plan you want to enroll in – check only one box:
Brand New Day for Seriously and Persistently Mentally Ill Plan Special Needs Plan (SPMI SNP- PBP 020):
❑ Los Angeles ❑ Orange ❑ Kern ❑ San Bernardino ❑ Riverside

Name of chosen Primary Care Physician (PCP), clinic or health center:	PCP Provider Code and/or Region number:
Contracting dentist you have chosen (if applicable):	Dental Facility # (if applicable):

PART 5: QUALIFYING SMI SNP QUESTIONS:

In order to be ***eligible for enrollment*** with Brand New Day a beneficiary must have a Serious Mental Disorder which means a mental disorder which is severe in degree and persistent in duration and which may cause behavioral disorder or impair functioning so as to interfere substantially with activities of daily living. Please note that these questions will be used in strict confidence and only as a means of qualifying a beneficiary for enrollment into this SNP Plan. All information is confidential, except in the case of sharing with Medicare.

1. Are you currently being treated for one of the following conditions:
   ❑ Schizophrenia ❑ Schizoaffective Disorder ❑ BiPolar Disorder (Manic Depression)
   ❑ Major Depression or ❑ Paranoid Disorder.
2. Are you currently receiving the following benefits? ❑ SSI and/or ❑ SSDI

PART 6: PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS:

1. Do you currently have End-Stage Renal Disease (ESRD) ❑ Yes ❑ No
   If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA Benefits, or State pharmaceutical assistance programs.
   Will you have other prescription drug coverage in addition to Brand New Day? ❑ Yes ❑ No
   If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	ID # for this coverage:	Group # for this coverage:

3. Are you enrolled in the Medi-Cal program? ❑ Yes ❑ No
   If yes, please provide your Medi-Cal (BIC) number: ______________________________

4. Do you or your spouse work? ❑ Yes ❑ No

5. Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' Compensation, or VA benefits? ❑ Yes ❑ No
   If yes, what kind of insurance do you have? ______________________________
   What is the name of your insurance? ______________________________

6. Are you a resident in a long-term facility, such as a nursing home? (e.g. nursing facility, rest home, rehabilitation hospital, convalescent home, etc.)? ❑ Yes ❑ No

If yes, name of Institution:	Phone number of Institution:	Your Date of Admission in Institution:

Address of institution (number and street):	City:	State:	Zip:

PART 7: PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining Brand New Day could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Brand New Day. 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.

PART 8: PLEASE READ, INITIAL AND SIGN BELOW:

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

1. Brand New Day 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 be in only 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 or prescription drug 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 when an enrollment period is available (Example: November 15 - December 31 of every year), or under certain special circumstances. _____ (***Initial***)

2. Brand New Day serves a specific service area. If I move out of the area that Brand New Day 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 Brand New Day, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Brand New Day when I get it to know which rules I must follow in order to receive coverage with the Medicare Advantage plan. I understand that people with Medicare aren't usually covered by Medicare while out of the country except limited coverage near the U.S. border. _____ (***Initial***)

3. I understand that beginning on the date Brand New Day coverage begins; I must get all of my health care from Brand New Day, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Brand New Day and other services contained in my Brand New Day Evidence of Coverage document (also know as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BRAND NEW DAY WILL PAY FOR THE SERVICES.** _____ (***Initial***)

4. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Brand New Day, he/she may be paid based on my enrollment in Brand New Day. _____ (***Initial***)

5. **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. 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 also acknowledge that Brand New Day 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. _______ (***Initial***)

6. I understand that my signature (or 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 by Brand New Day or by Medicare. _______ (***Initial***)

Applicant Signature: **Today's Date:**

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

Signature: ____________________ **Print Name:** ____________________

Relationship to Enrollee: ____________________

Address: ____________________ **Phone Number:** ____________________

Documentation Type: ❑ DPOA ❑ DPAHC ❑ Written Advance Directive ❑ Legal Guardian

If anyone helped the individual fill out this form (with the exception of the effective date), she/he must sign the following line:

Signature: ____________________ **Date:** ____________________

Relationship to applicant: ____________________

Enroll by: ❑ Phone-Tracking #____________ ❑ Web-Tracking #____________ ❑ Grp Seminar ❑ In-Home

Brand New Day Office Use Only:

Date of Receipt: ______________ Date Entered: _____________ Plan ID# _____________________ Initials of Verification Rep: ____________

Date E4 Letter Sent out: _________________ Date E6 Letter Sent Out: __________________ Effective Date of Coverage: _________________

Plan Rep Name: _________________________________ Group #: ________________________ Part D Premium: ____________________

ICEP: _______________ OEP: _______________ AEP: _______________ SEP (type): _______________ LIS: ________________________

Notes:____