



Health Choice Generations  
410 North 44th Street  
Suite 510  
Phoenix, AZ 85008

1-800-656-8991

TTY: 1-800-842-4681

[www.hcgenerations.com](http://www.hcgenerations.com)

---

**\* Important \***

**Before you fill out each form,  
please insert the enclosed chipboard  
between each  
three page carbon sheet.**

**WHITE Copy = Health Choice Generations**

**PINK Copy = Beneficiary**

**YELLOW Copy = Broker**

---

## 2009 Enrollment Request Form



Health Choice Generations  
410 North 44th Street, Suite 510  
Phoenix, AZ 85008

Phone: 1-800-656-8991  
www.hcgenerations.com TTY Users Call: 1-800-843-4681

### To Enroll in Health Choice Generations, Please Provide the Following Information:

LAST name:	FIRST Name:	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date: ( ___ / ___ / ___ ) (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	(Optional) Social Security Number:	Home Phone Number: (    )
Permanent Residence Street Address:			
City:	State:	ZIP Code:	
Mailing Address (only if different from your Permanent Residence Address):			
Street Address:	City:	State:	ZIP Code:
Emergency contact: _____			
Phone Number: _____		Relationship to You: _____	
Optional field: E-mail Address: _____			

### 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.

<b>MEDICARE</b> <b>HEALTH INSURANCE</b>
SAMPLE ONLY
Name: _____
Medicare Claim Number _____ Sex _____
_____ - _____ - _____
Is Entitled To _____ Effective Date _____
HOSPITAL (Part A) _____
MEDICAL (Part B) _____

**Please read and answer these important questions:**

1. Do you 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 Health Choice Generations?  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 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): \_\_\_\_\_

4. Are you enrolled in your State Medicaid program?  Yes  No

If yes, please provide your Medicaid number: \_\_\_\_\_

5. Do you or your spouse work?  Yes  No

*Optional field: Please choose the name of a Primary Care Physician (PCP), clinic or health center:*

**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:**

\_\_\_ Spanish

\_\_\_ Electronic via E-Mail

Please contact Health Choice Generations at 1-800-656-8991 (TTY users should call 1-800-842-4681 if you need further information in another format or language than what is listed above. Our office hours are 8 a.m. to 8 p.m daily.



## Please Read This Important Information

If you currently have health coverage from an employer or union, joining Health Choice Generations could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Health Choice Generations 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.

## Please Read and Sign Below

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

Health Choice Generation is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my 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.

Health Choice Generations serves a specific service area. If I move out of the area that Health Choice Generations 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 Health Choice Generations, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Choice Generations, when I receive it, to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Health Choice Generations coverage begins, I must get all of my health care from Health Choice Generations, with the exception of emergency or urgently needed services or out-of-area dialysis services.

Services authorized by Health Choice Generations and other services contained in my Health Choice Generations Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH CHOICE GENERATIONS WILL PAY FOR THE SERVICES.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Health Choice Generations, he/she may be compensated based on my enrollment in Health Choice Generations.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

**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 Health Choice Generations 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 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 Health Choice Generations or by 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: \_\_\_\_\_ OEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP (type): \_\_\_\_\_ Not Eligible: \_\_\_\_\_

Broker Name: \_\_\_\_\_

Packet left with beneficiary (circle one)      yes      no

How did beneficiary hear about Health Choice Generations? \_\_\_\_\_