Carefully read these instructions before filling out the application. Please complete the application using a ballpoint pen.

1. **Selecting a network Provider of Choice.** Please select a "Provider of Choice" to assist you in maintaining and improving your health status or for care in the treatment of an illness. You are not required to choose a traditional primary care provider. We also do not require a referral for you to see another physician within our network. A provider of choice may be virtually any physician from our network who will be primarily responsible for your care and treatment. If you need assistance making a selection please consult your enrollment counselor or call Customer Service at 615-782-7878 or toll free 1-800-316-2273. (TTY users should call 1-866-460-7617). We are available seven days a week, 7 a.m. to 8 p.m. Central Time.
2. **If possible, copy your Medicare Card.** Please make a copy of your Medicare card to include with the application. If you are unable to include a copy of the card, please be sure to complete the section on the first page related to your Medicare card.
3. **Complete the Health Assessment.** If you require immediate coordination of your health care needs (i.e. health care equipment such as oxygen tank or if you require home health care) please complete this form so your care will not be interrupted.
4. **Authorization for Automatic Withdrawal Form.** If you would like to have your premiums withdrawn directly from your checking account or credit card, please complete the Authorization for Automatic Withdrawal (Bank Draft or Credit Card) Form. Until the form is received and processed by Windsor Medicare Extra, you will get a bill.
5. **Mail your application.** After completing the application and the forms listed above, if applicable, please sign and return them to Windsor Medicare Extra. When mailing an application, Windsor Medicare Extra will determine your effective date based on the date Windsor Medicare Extra receives your application.

   Windsor Health Plan, Inc.
   Attn: Enrollment Applications
   7100 Commerce Way, Suite 285
   Brentwood, TN 37027

6. **Verification Phone Call.** Within five business days of receiving your application at Windsor Medicare Extra, we will make three attempts to reach you by phone. The purpose of this call is to verify the information you provided on this application is correct and to confirm your understanding of our plan rules. Please provide the verification call phone number if it differs from the phone numbers requested on this enrollment application.

Confirmation of Eligibility by Medicare (Centers for Medicare & Medicaid Services (CMS))
After we receive your completed application the necessary information will be sent to CMS, the governmental agency that administers Medicare. One copy of this application will be returned to you. Once your eligibility has been verified and confirmed by CMS we will notify you in writing about the status of your application.

Thank you,
Windsor Medicare Extra

Windsor Medicare Extra is a product of Windsor Health Plan, Inc., a Medicare Advantage organization with a Medicare contract.

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you don't add or drop your prescription drug coverage (i.e. if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage you can only change to another plan without Medicare prescription drug coverage). Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

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 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 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 or long term care facility). 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.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) ____________.
- ☐ None of these statements applies to me.*

*Please contact Windsor Medicare Extra at 1-800-316-2273 (TTY users should call 1-866-460-7617) to see if you are eligible to enroll. We are open 7 a.m. - 8 p.m. Central Time, seven days a week.

Please contact Windsor Medicare Extra if you need information in another language or format (Braille).

To Enroll in Windsor Medicare Extra, Please Provide the Following Information:

Please check which plan you want to enroll in:

☐ Comp Plus Plan (HMO) 128 ....$28.40 monthly*

☐ Comprehensive Plan (HMO) 022 (CNTAR) ....$38.00 monthly*

☐ Comprehensive Plan (HMO) 058 (NWAR) ....$28.40 monthly*

**LIS Assistance 100% Premium= $0.00*

FIRST Name:	LAST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (MM/DD/YYYY) (_____/_____/______)	Sex: ☐ Male ☐ Female	Home Phone Number: ( )_____-_______	Verification Call Number *(if different)*: ( )_____-_______
Permanent Residence Street Address (P.O. Box is not allowed):			County:
City:		State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):

Street Address: City: State: ZIP Code:

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 Social Security or the Railroad Retirement Board.

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

MEDICARE HEALTH INSURANCE

Name ______________________

Medicare Claim Number ______-______-______ ___

Sex ____________

Is Entitled To

Effective Date

HOSPITAL (Part A) ____________

MEDICAL (Part B) ____________

H5698 EAPP003 0909 CMS Approval: 10/2009

Paying Your Plan Premium

You can pay your monthly plan premium by mail, bank draft or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

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 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 bill.
- ☐ Draft your bank account each month. Complete the Authorization for Bank Draft form.
- ☐ Credit Card. Please complete Credit Card Authorization form. Call 1-800-316-2273 to request a form.
- ☐ 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.) ___________ ***initials***

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 don't need regular dialysis any more, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't 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 Windsor Medicare Extra? ☐ 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   Are you: ☐ QMB ☐ SMB ☐ SSI ☐ QI

If yes, please provide your Medicaid number: ______________________ SSN: ______________________

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

You MUST use providers from the Windsor Medicare Extra Network. Please select your Network Provider of Choice:

☐ Name: ______________________________ Provider ID #: ______________________

- OR -

☐ I will choose a NETWORK Provider later using the Provider Directory or by calling Customer Service.

___________ ***initials***

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:

- ☐ Large Print
- ☐ Audio CD

Please contact Windsor Medicare Extra at 1-800-316-2273 if you need information in another format or language than what is listed above. Our office hours are 7 a.m. - 8 p.m. Central Time, seven days a week. TTY users should call 1-866-460-7617.

Name: ____ MAPD P3

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Windsor Medicare Extra could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Windsor Medicare Extra. 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 isn't any 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: Windsor Medicare Extra 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. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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.

Windsor Medicare Extra serves a specific service area. If I move out of the area that Windsor Medicare Extra 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 Windsor Medicare Extra, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Windsor Medicare Extra 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 Windsor Medicare Extra coverage begins, I must get all of my health care from Windsor Medicare Extra, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Windsor Medicare Extra and other services contained in my Windsor Medicare Extra Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, NEITHER MEDICARE NOR WINDSOR MEDICARE EXTRA 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 Windsor Medicare Extra, he/she may be paid based on my enrollment in Windsor Medicare Extra.

Release of Information: By joining this Medicare health plan, I acknowledge that Windsor Medicare Extra will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Windsor Medicare Extra 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 by Windsor Medicare Extra or by Medicare.

With my signature, I agree to allow Windsor Medicare Extra to obtain information needed for eligibility verification from my State or Federal agency or a third party company that works with my State.

Signature: ______________________________ **Today's Date:** ______________

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

Name: ______________________________

Address: ______________________________

Phone Number: ______________ **Relationship to Enrollee:** ______________

Office Use Only:

Name of staff person/agent/broker (if assisted in enrollment): ______________________________

Plan ID#: ______________________ Effective Date of Coverage: ____/____/____

ICEP/IEP: ________ OEP: ________ AEP: ________ SEP (type): ________

☐ Seminar ☐ In-Home ☐ SG ☐ CG ☐ OG ☐ TE ☐ PC

Agent ID#: ____________ Agent Signature: ______________________ Date: ____/____/____