brand new day

HEALTHCARE YOU CAN FEEL GOOD ABOUT

To enroll in Brand New Day Health Maintenance Organization (HMO) or Special Needs Plan (SNP), please provide the following information.

TO ENROLL IN BRAND NEW DAY, PLEASE PROVIDE THE FOLLOWING INFORMATION

PROPOSED EFFECTIVE COVERAGE DATE:

Please Select a Plan: If you have Medi-Cal with no share of cost and the State pays your premium, the plans with a premium may be your best choice.
Please contact Brand New Day if you need information in another language or format (Braille).

CLASSIC CARE DRUG SAVINGS (HMO) PLAN 25

☐ Los Angeles, Orange, Riverside, San Bernardino, San Diego and Kern Counties $0 per month

CLASSIC CHOICE FOR MEDI-MEDI (HMO) PLAN 33

☐ Los Angeles, Orange, Riverside, San Bernardino, Kings, Kern, Imperial, San Diego, Fresno, Tulare, Santa Clara and San Mateo Counties $35.50 per month

CLASSIC CARE DRUG SAVINGS (HMO) PLAN 37

☐ Imperial, San Mateo, Santa Clara, Fresno, Kings and Tulare Counties $0 per month

DUAL COVERAGE FOR MEDI-MEDI (HMO D-SNP) PLAN 24

☐ Kings and Kern Counties $35.50 per month

EMBRACE CARE DRUG SAVINGS (HMO C-SNP) PLAN 35

☐ Los Angeles, Orange, Riverside, San Bernardino, Kings, Kern, Imperial, San Diego, Fresno, Tulare, Santa Clara and San Mateo Counties $0 per month

EMBRACE CHOICE FOR MEDI-MEDI (HMO C-SNP) PLAN 36

☐ Los Angeles, Orange, Riverside, San Bernardino, Kings, Kern, Imperial, San Diego, Fresno, Tulare, Santa Clara and San Mateo Counties $35.50 per month

BRIDGES DRUG SAVINGS (HMO C-SNP) PLAN 28

☐ Los Angeles, Orange, Riverside, San Bernardino, and Kern Counties $0 per month

BRIDGES CHOICE FOR MEDI-MEDI (HMO C-SNP) PLAN 29

☐ Los Angeles, Orange, Riverside, San Bernardino, and Kern Counties $35.50 per month

INFORMATION ABOUT YOU

☐ MALE ☐ FEMALE

LAST NAME | FIRST NAME | M.I.

BIRTH DATE (MM/DD/YYYY) | HOME PHONE NUMBER | CELL PHONE NUMBER

PERMANENT RESIDENCE STREET ADDRESS | APT # OR SPACE #

CITY | STATE | ZIP

CA

MAILING ADDRESS IF DIFFERENT THAN PERMANENT ADDRESS | APT # OR SPACE #

CITY | STATE | ZIP

EMAIL ADDRESS (OPTIONAL)

EMERGENCY CONTACT NAME (OPTIONAL) | PHONE NUMBER (OPTIONAL)

RELATIONSHIP TO APPLICANT

PREFERRED LANGUAGE FOR WRITTEN MATERIALS

☐ ENGLISH ☐ SPANISH ☐ CHINESE ☐ KOREAN ☐ VIETNAMESE

RACE/ETHNIC GROUP (OPTIONAL)

☐ WHITE-NON HISPANIC ☐ BLACK-NON HISPANIC ☐ HISPANIC OR LATINO ☐ ASIAN

☐ NATIVE AMERICAN/PACIFIC ISLANDER ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ TWO OR MORE RACES (NOT HISPANIC OR LATINO)

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please use 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 Railroad Retirement Board

MEDICARE HEALTH INSURANCE

Name (as is 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.

PLEASE PROVIDE YOUR DOCTOR CHOICE

NAME OF CHOSEN PRIMARY CARE PHYSICIAN (PCP, CLINIC OR HEALTH CENTER)

PCP PROVIDER CODE & IPA#

CONTRACTED DENTIST (ONE WILL BE ASSIGNED IF LEFT BLANK)

DENTAL FACILITY #

PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

1) 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

2) Are you a resident of a group home, assisted living or Board and Care? If yes, please provide the following information: ☐ Yes ☐ No

NAME OF INSTITUTION OR HOME

ADDRESS & PHONE NUMBER OF INSTITUTION (NUMBER AND STREET)

3) Do you have Medi-Cal? If yes, please provide your Medi-Cal number. ☐ Yes ☐ No

4) Do you have End-Stage Renal Disease (ESRD)? If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information. ☐ Yes ☐ No

5) Do you, on your own or through your spouse, have any other health insurance other than Medicare such as private insurance, TRICARE, Federal Employee Health Benefits Program, Union Plan, workers' compensation, third party liability, state pharmaceutical assistance program or VA benefits? ☐ Yes ☐ No

6) Will you have this medical or prescription drug coverage in addition to Brand New Day? If yes, please list your other coverage and your identification (ID) number(s) for this coverage: ☐ Yes ☐ No

NAME OF OTHER MEDICAL OR DRUG COVERAGE

GROUP # FOR THIS MEDICAL OR DRUG COVERAGE

ID # FOR THIS MEDICAL OR DRUG COVERAGE

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 isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

- ☐ I am new to Medicare
- ☐ I have a diagnosis that qualifies for a Brand New Day Special Needs Plan
- ☐ 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 (Medi-Cal) or my state helps pay for my Medicare premiums
- ☐ I have lost my Medicaid (Medi-Cal) coverage
- ☐ 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 leaving my employer or union coverage on (insert date) __ __/ __ __/ __ __
- ☐ 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) __ __/ __ __/ __ __
- ☐ If none of these statements apply to you or you are not sure, please contact Brand New Day at 1-866-255-4795 TDD/TYY users call 1-866-321-5955
- ☐ Other: Please Explain _____

EXTRA HELP FOR MEDICATION COVERAGE

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 coinsurance. 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. TYY users should call 1-800-325-0778.

You can also apply for extra help online at www.ssa.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 coupon book.

You can pay your monthly premium (including any late enrollment penalty that you currently 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 (RRB) Benefit 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 RRB. DO NOT PAY Brand New Day the Part D-IRMAA.

EXTRA HELP FOR MEDICATION COVERAGE

PLEASE SELECT A PREMIUM PAYMENT OPTION:

☐ Get a Bill ☐ Get a Coupon Book

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

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as necessary for treatment, payment and healthcare operations. I also acknowledge that Brand New Day will release my information 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.

PLEASE READ AND SIGN BELOW

SIGNATURE **TODAY'S DATE**

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

NAME **RELATIONSHIP TO APPLICANT**

ADDRESS **PHONE NUMBER**

DOCUMENTATION TYPE:

☐ DPOA ☐ DPAHC ☐ Written Advance Directive ☐ Legal Guardian

Please submit documentation with enrollment paperwork.

SALES AGENT INFORMATION

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

NAME OF STAFF/AGENT/BROKER (print name)

SIGNATURE **DATE**

RELATIONSHIP TO APPLICANT **DATE APPLICATION WAS RECEIVED**

AGENT PHONE NUMBER **AGENT LICENSE NUMBER** **FMO**

Please Fax Application with Scope of Appointment to Brand New Day's Enrollment Department Fax Number 1-657-400-1207

OFFICE USE ONLY

Date of Receipt: _____ Date: _____ Plan: _____ Initials of Verification: _____

Date E4 Letter Sent: _____ Date E6 Letter Sent: _____ Rep: _____

Name of Staff Member/Agent/Broker (if assisted): _____

Group #: _____ Part D Premium: _____

☐ SEP ☐ LIS ☐ ICEP/IEP ☐ AEP ☐ Not Eligible

Notes: _____

_____