TRIPLE-S ADVANTAGE

2020 INDIVIDUAL ENROLLMENT FORM

Scope of Appointment #: _____ ON BASE ID: _____

Please contact Triple-S Advantage if you need information in another language or format (e.g.Braille).

TO ENROLL IN TRIPLE-S ADVANTAGE, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Please check which plan you want to enroll in:

☐ Contigo Plus (HMO-SNP)
Monthly Premium $0

☐ Royal (HMO)
Monthly Premium $0

☐ Enlace (HMO)
Monthly Premium $0

☐ Magno (HMO-POS)
Monthly Premium $0

☐ Royal Plus (HMO-POS)
Monthly Premium $45

☐ Brillante (HMO-POS)
Monthly Premium $0

☐ Basic (HMO)
Monthly Premium $0

☐ Óptimo (PPO)
Monthly Premium $0

☐ Óptimo Plus (PPO)
Monthly Premium $99

If you choose to enroll in **Contigo Plus (HMO-SNP)**, please select the chronic condition that you have been diagnosed: ____Diabetes Mellitus ____Cardiovascular Disorder ____Chronic Heart Failure

Some of our plans include an extended care package. If you choose to enroll in **Contigo Plus** or **Enlace**, you must select one of the benefits below at no extra cost ($0). The benefit you select will be effective from the first day your enrollment takes effect and while you are a member of **Contigo Plus** or **Enlace** or until December 31, 2020. Your benefit selection on this enrollment form is final and you may not change it during the year.

Contigo Plus:

If you enroll in Contigo Plus, select one (1) of these five (5) benefits:

____ Eyewear* - Up to $500 per year as an added value to the standard supplemental eyewear benefit.

____ Transportation* - Up to ten (10) trips per year as an added benefit to the standard supplemental benefit.

____ Dental* - Up to $1,000 per year as an added value to the standard supplemental comprehensive dental benefit.

____ Hearing Aid* - Up to $1,000 every three (3) years as an added value to the standard supplemental hearing aid benefit.

____ Over the Counter (OTC)* - Up to $35 every three (3) months as an added value to the standard supplemental OTC benefit.

Enlace:

If you enroll in Enlace, select one (1) of these five (5) benefits:

____ Eyewear* - Up to $300 per year as an added value to the standard supplemental eyewear benefit.

____ Transportation* - Up to twenty-four (24) trips per year as an added benefit to the standard supplemental benefit.

____ Dental* - Up to $500 per year as an added value to the standard supplemental comprehensive dental benefit.

____ Hearing Aid* - Up to $1,000 per year as an added value to the standard supplemental hearing aid benefit.

____ Over the Counter (OTC)* - Up to $25 every three (3) months as an added value to the standard supplemental OTC benefit.

*Benefit follows the same restrictions as the standard supplemental benefit.

PLEASE INDICATE IN WHICH GROUP PLAN YOU WANT TO ENROLL IN (IF APPLICABLE):

Coverage: _____ Choose: ☐ (HMO) ☐ (PPO)

Monthly Premium: _____ Effective Date: _____

Please read this Important Information: If you currently have health coverage from an employer or union, joining Triple-S Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Triple-S Advantage. 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.

BENEFICIARY INFORMATION

Mr.☐ Mrs.☐Ms.☐

Last Names: First Name: Middle Initial:

_____ _____ _____

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

Home Phone Number: _____ Alternate Phone Number:_____

Permanent Residence Street Address (P.O. Box is not allowed):

_____

City: _____, PR Zip Code: _____

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

_____

City: _____, PR Zip Code: _____

Emergency Contact: _____

Relationship with you: _____ Phone Number: _____

E-mail Address: _____

Current Health Plan: _____ Coverage: _____

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 the 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

For members who are enrolling in a <u>plan with ZERO PREMIUM:</u>
If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail, "Electronic Funds Transfer (EFT)", or "credit card" 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 RRB. DO NOT pay Triple-S Advantage, Inc. the Part D-IRMAA.

For members who are enrolling in a <u>plan with PREMIUM:</u>
You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, "Electronic Funds Transfer (EFT)", or "credit card" 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 RRB. DO NOT pay Triple-S Advantage Inc. 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 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 coupon book.

PLEASE SELECT A PREMIUM AND/OR LATE ENROLLMENT PENALTY PAYMENT OPTION:

__☐__ Get a coupon book

__☐__ 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

__☐__Credit Card Please provide the following information:

Type of card: _____*Visa* _____*Master Card*

Name of account holder as it appears on card: _____

Account number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Expiration date: _ _/_ _ _ _ (MM/YYYY)

__☐__ 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.)

PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS:

1. Are you the retiree? Yes ☐ No ☐ (only for employer groups)
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? (only for employer groups)
☐ Yes ☐ No ☐ Not applicable
If yes, name of spouse: _____
Name(s) of dependent(s): _____

3. Do you have End Stage Renal Disease (ESRD)? Yes ☐ No ☐
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.

4. 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 Triple-S Advantage?
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
_____ _____ _____

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):
_____

6. Are you enrolled in your state's Medicaid Program of the Health Department?
Yes ☐ No ☐
If yes, please provide your Medicaid number: _____

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

Please, choose the name of a Primary Care Physician (PCP), from our Providers Directory:

_____ **Phone Number:** _____

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

Other language: ☐ Spanish ☐ Other, indicate: _____

Other format: ☐ Braille ☐ Audio CD ☐ Other, indicate: _____

Please contact Triple-S Advantage at 1-888-620-1919 if you need information in an accessible format or language other than what is listed above. Our office hours are Monday through Sunday from 8:00 a.m. to 8:00 p.m. TTY users should call 1-866-620-2520.

PLEASE READ AND SIGN BELOW

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

1. Triple-S Advantage is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B.
2. 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 or prescription drug plan.
3. It is my responsibility to inform Triple-S Advantage of any prescription drug coverage that I have or may get in the future.
4. For Óptimo (PPO) and Basic (HMO): 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.
5. Enrollment in this plan is generally for the entire year.
6. 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: during the Annual Enrollment Period from October 15 – December 7 of every year), or under certain special circumstances.
7. Triple-S Advantage serves a specific service area. If I move out of the area that Triple-S Advantage serves, I need to notify the plan so I can disenroll and find a new plan in my new area.
8. Once I am a member of Triple-S Advantage, I have the right to appeal plan decisions about payment or services if I disagree.
9. I will read the Evidence of Coverage document from Triple-S Advantage when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.
10. 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.
11. I understand that beginning on the date Triple-S Advantage coverage begins, I must get all of my health care from Triple-S Advantage, except for emergency, urgently needed services or out-of-area dialysis services.
12. (For PPO Plans) I understand that beginning on the date Triple-S Advantage coverage begins, using services in-network, can cost less than using services out-of-network, except for emergency, urgently needed services or out-of-area dialysis services. Out-of-network/non-contracted providers are under no obligation to treat Triple-S Advantage, Inc. members, except in emergency situations. 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.
13. If medically necessary, PPO plans, provide refunds for all covered benefits, even if I get services out of network.
14. Services authorized by Triple-S Advantage and other services contained in my Triple-S Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR TRIPLE-S ADVANTAGE WILL PAY FOR THE SERVICES.**

15. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Triple-S Advantage, he/she may be paid based on my enrollment in Triple-S Advantage.
16. **Release of Information:** By joining this Medicare health plan, I acknowledge that Triple-S Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Triple-S Advantage 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.

I certify to have received the following documents from the Triple-S Advantage representative:

- ☐ **Initial Package** (Multi-language Notification, Nondiscrimination Notice, Summary of Benefits, Pre-Enrollment Checklist)
- ☐ Medicare Star Rating Notice
- ☐ Evidence of Coverage, Drug Formulary and Provider and Pharmacy Directory Notice
- ☐ Evidence of Coverage and Durable Medical Equipment Formulary (if applicable)
- ☐ Provider and Pharmacy Directory (if applicable)
- ☐ Drug Formulary (if applicable)
- ☐ Precertification of Chronic Disease (if applicable)
- ☐ Enrollment Form Copy (if applicable)
- ☐ Electronic Enrollment Confirmation (if applicable)
- ☐ Attestation of Eligibility for an Enrollment Period (if applicable)
- ☐ Authorization to Disclose Protected Health Information (if applicable)

Authorization to receive information electronically:
By providing your email address and cell phone, you authorize Triple S Advantage to send the following materials by email or text messages as applicable: Provider Directory, Annual Notice of Change, Evidence of Coverage, Summary of Benefits, Prescription Drug Formulary, promotional material to maintain their health, appointment reminders, and any other health communication of the Plan. If you do not wish to receive communications via email or text messages, you can communicate anytime to our Member Service Center at 1-888-620-1919 and TTY (hearing impaired) should call 1- 866-620-2520 Monday through Sunday from 8:00 am to 8:00 pm.

☐ Agree to receive information by: ☐ e-mail ☐ text messages.

☐ Do not Agree to receive information by: ☐ e-mail ☐ text messages.

Signature: _____ **Today's date:** _____

Witness: _____ **Today's date:** _____

If you are the authorized representative/legal 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 the enrollment) _____

NPN: _____

Plan ID # _____ Effective Date of Coverage _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not eligible: _____

MA OEP: _____

Triple-S Advantage, Inc. is an independent licensee of BlueCross BlueShield Association.

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