Please print out the form below and mail your completed form to:

SecureHorizons Enrollment Services

Attention: Rick Plata
23331 Via Sausalito
Moreno Valley, CA 92557

Or

Fax to: (888) 391- 0562

Enrollment questions, please call Rick Plata at (888) 235-8060

Individual Enrollment Request Form

1. Applicant Information (Please type or print in black or blue ink.)

Last Name	First Name	Middle Initial

Birth Date ____ / ____ / ____	Gender ☐ Male ☐ Female	☐ Mr. ☐ Mrs. ☐ Ms.

Home Telephone Number ( )	Work/Cell Telephone Number (optional) ( )

Permanent Residence Street Address (not a PO Box)

City	State	ZIP Code	County

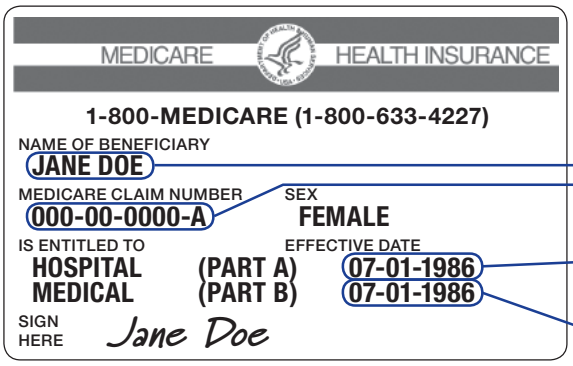
Alternate Mailing Address (only if different from your Permanent Residence Street Address)

City	State	ZIP Code

E-mail Address (optional)

2. Medicare Information

Please take out your red, white and blue Medicare card to complete this section — OR — Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.



Beneficiary's Name (exactly as it appears)

___ ___ ___ – ___ ___ – ___ ___ ___ ___ – ___

Medicare Claim Number Letter(s)

Part A (Hospital) effective date ____ / ____ / ____

Part B (Medical) effective date ____ / ____ / ____

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

3. Your Payment Options (If applicable)

If you have a plan premium AND/OR we determine that you owe a late-enrollment penalty, the amount can be automatically deducted from your Social Security benefit check. The automatic deduction from your monthly Social Security benefit check may take two or more months to begin. In most cases, the first deduction will include all premiums due from your enrollment effective date up to the point withholding begins. If you don't choose this option, we will provide you a coupon book or you can sign up for 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 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, it is recommended you choose the coupon book or EFT option. Unless checked otherwise, you will receive a coupon book for the amount that Medicare doesn't cover. If you would like to set up EFT, please enclose a blank check with VOID written on the front.

If there is a plan premium, and/or a late enrollment penalty, deduct the total amount from my:
(Choose only ONE payment method. You must initial your selection. If nothing is checked, you will receive a coupon book.)

☐ **Monthly Social Security benefit check** ____ *(Initials)* ☐ **Coupon Book** ____ *(Initials)*

☐ **Electronic Funds Transfer (EFT)** from your bank account each month. ____ *(Initials)* Enclose a **VOIDED** check OR provide the following:

Account Holder Name _____ Bank Routing Number _____

Bank Account Number _____ Account Type: ☐ Checking ☐ Savings

4a. Benefit Plan Selections — Choose Only One:

Health Maintenance Organization (HMO) plans with a medical **and** Part D drug benefit:

☐ AARP® MedicareComplete® (HMO)
☐ AARP® MedicareComplete® Plan 1 (HMO)
☐ AARP® MedicareComplete® Plan 2 (HMO)
☐ AARP® MedicareComplete® Plan 3 (HMO)
☐ AARP® MedicareComplete® Plan 4 (HMO)
☐ AARP® MedicareComplete® Value (HMO)
☐ AARP® MedicareComplete® Premier (HMO)
☐ AARP® MedicareComplete® Balance (HMO)
☐ AARP® MedicareComplete® Mosaic (HMO)

HMO plans with medical benefits only:

☐ AARP® MedicareComplete Essential® (HMO)

Preferred Provider Organization (PPO) plans with a medical **and** Part D drug benefit:

☐ AARP® MedicareComplete Choice® (PPO)
☐ AARP® MedicareComplete Choice® Plan 1 (PPO)
☐ AARP® MedicareComplete Choice® Plan 2 (Regional PPO)
☐ AARP® MedicareComplete Choice® (Regional PPO)

PPO plans with medical benefits only:

☐ AARP® MedicareComplete Choice® Essential (PPO)
☐ AARP® MedicareComplete Choice® Essential (Regional PPO)

Point of Service (HMO-POS) plans with a medical **and** Part D drug benefit:

☐ AARP® MedicareComplete® Plus (HMO-POS)
☐ AARP® MedicareComplete® Balance Plus (HMO-POS)
☐ AARP® MedicareComplete® Plus Plan 1 (HMO-POS)
☐ AARP® MedicareComplete® Plus Plan 2 (HMO-POS)

HMO-POS plans with medical benefits only:

☐ AARP® MedicareComplete® Plus Essential (HMO-POS)

4b. Contract Information — Refer to Cover of Summary of Benefits

Contract/H # _____ PBP/Plan# _____

Complete the following if the plan chosen includes routine dental coverage:

Name of dental provider _____ Provider I.D. # (please refer to Dental Directory) _____

Are you currently a patient of this dentist? ☐ Yes ☐ No

4c. OPTIONAL: Supplemental Benefit Plans

These plans are not available in all service areas. You can choose both the Fitness AND the Deluxe Rider.

Please review the Summary of Benefits to confirm availability and to learn about any applicable premiums.

☐ Fitness Rider ☐ Deluxe Rider

Choose ONLY one dental plan OR the Deluxe Rider listed above.

☐ Optional Dental Rider ☐ High Option Dental Rider ☐ Dental Silver Rider ☐ Dental Gold Rider ☐ Dental 260 Rider

Dental Facility # (please refer to the Dental Directory) _____

You do not need to select a Dental Facility for the following plans. ☐ Dental 467 Rider ☐ Dental Platinum Rider

5. Primary Care Physician (PCP) Selection

Refer to your Provider Directory to select a PCP. PCP name _____

Provider I.D. # _____ Are you currently a patient of this physician? ☐ Yes ☐ No

6. Please Read and Answer These Important Questions

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

If you answered yes 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 physician showing you don't need dialysis or have had a successful kidney transplant. (Use Form 2728 if available.)

If yes, are you currently a member of a health care company? ☐ Yes ☐ No

If yes, name of company _____ I.D. # _____

Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)? ☐ Yes ☐ No

If yes, name of institution _____

Address of institution _____ City, State _____

Telephone number of institution (_____) _____ Your date of admission to the institution ____ /____ /____

Are you enrolled in your state Medicaid program? ☐ Yes ☐ No

If yes, please provide your Medicaid number _____

Do you or your spouse work? ☐ Yes ☐ No

Do you or your spouse have any health insurance other than Medicare, such as private insurance, Workers' Compensation, or Veterans Administration (VA) benefits? ☐ Yes ☐ No

If you have other health insurance, what kind do you have? _____

What is the name of the health insurance? _____

Group# _____ I.D. # _____

Do you have any other prescription drug coverage such as private insurance, TRICARE, VA benefits, State Pharmaceutical Assistance Program or Federal Employee Health Benefits coverage? ☐ Yes ☐ No

Plan name of other coverage _____

I.D. # for this coverage _____

7. Please Read This Important Information

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 enrollment request form means that I have read, understand and agree to the contents of this enrollment request form, Statements of Understanding and the Additional Statement of Understanding (for the plan I have chosen) on the back of this form.

Please initial the plan you have chosen: HMO _____ **PPO** _____ **POS** _____

You must sign and date this Individual Enrollment Request Form in order for it to be processed.

If signed by an authorized representative of the applicant, this signature certifies the person is authorized under state law to complete this enrollment request form and make health care decisions on behalf of the applicant and is authorized to receive health care related information on his/her behalf and that documentation of this authority is available upon request by the plan or by CMS. I will notify the plan if the authority to receive health care related information changes.

Signature of applicant/member/authorized representative	Date ____ /____ /____
Signature of individual who assisted in completing this request form and/or witness	Date ____ /____ /____
Relationship to applicant *(if you assisted in completing this request form)*	

If you are the authorized representative of the applicant, you must provide the following information and sign above.

Name			Relationship to applicant
Address			Telephone Number ( )
City	State	ZIP Code	Work/Cell Telephone Number ( )

8. Alternative Formats

If available, I prefer to receive materials in the following format: ☐ Spanish ☐ Chinese ☐ Large Print

Please contact SecureHorizons® at 1-800-547-5514 if you need information in another format or language than those listed above. Our office hours are 8 a.m. – 8 p.m. local time, 7 days a week. TTY users should call 711.

9. For Sales Representative/Agency Use Only

Selling Staff Member/Agent I.D.	Initial Receipt Date	Election Period: ☐ AEP ☐ ICEP ☐ IEP ☐ OEPI ☐ OEPNEW ☐ OEP ☐ SEP _____ (SEP Reason Code)
Selling Staff Member/Agent Name	Proposed Effective Date	
Agency	Agent Telephone Number	
Signature		

Statements of Understanding

By Completing This Enrollment Request Form, I Agree to the Following:

1. AARP® MedicareComplete® is a Medicare Advantage Plan and has a contract with the Federal Government. I must keep my Medicare Parts A and B by continuing to pay the Part B premiums and, if applicable, Part A premiums, if not otherwise paid for under Medicaid or by another third party. I can only be in one Medicare Advantage plan or Medicare Advantage Prescription Drug plan at a time. By enrolling in this plan, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS), from any other Medicare Advantage (MA) plan of which I may be a member. It is my responsibility to inform the plan of any prescription drug coverage that I have or may get in the future. For MA-only plans: 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, unless special election periods apply. 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), by sending a request to the plan or by calling 1-800-MEDICARE (1-800-633-4227); (hearing impaired users should call 1-877-486-2048), 24 hours a day, 7 days a week.
2. I understand that I must live in the service area and if I move out of the service area, I must notify the plan of the move. I understand that if I permanently move out of the service area, CMS requires that the plan disenroll me. 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.
3. I understand that as a member of this plan, I have the right to appeal plan decisions about payments or services if I disagree. I understand that I will be bound by the benefits, copayments, exclusions, limitations and other terms of the plan. It is my responsibility to read the Evidence of Coverage when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage plan and the amounts for which I will be responsible for payment under the plan.

Statements of Understanding, continued

4. By joining this Medicare Advantage plan, I acknowledge that the Medicare Advantage plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge the plan will release my information, including my prescription drug event data if applicable, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment request form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this enrollment request form, I may be disenrolled from the plan.
5. I understand that if I previously had prescription drug coverage or any insurance that included drugs, I may be asked for proof that my previous prescription drug coverage was at least as good as Medicare's standard prescription drug coverage (creditable prescription drug coverage). I can send copies of my proof with this form or I can wait until I am asked for it. I don't have to send proof to enroll. However, if I am asked for my proof and I don't provide it, my premium may be increased because of a late enrollment penalty. For more information about the late enrollment penalty, I may visit www.medicare.gov or 1-800-MEDICARE (1-800-633-4227); (hearing impaired users should call 1-877-486-2048), 24 hours a day, 7 days a week.
6. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.

Additional Statements of Understanding for Each Specific Plan:

AARP® MedicareComplete® from SecureHorizons (HMO)
I understand that beginning on the date AARP® MedicareComplete® from SecureHorizons plan coverage begins, I must receive all covered benefits from plan contracted providers and pharmacies, except for emergency or urgently needed services or out-of-area renal dialysis. I understand that authorized services and other services contained in my Evidence of Coverage document will be covered as disclosed. If I do not receive prior authorization as required for covered services, I understand that neither Medicare nor AARP® MedicareComplete® will pay for services.

AARP® MedicareComplete Choice® (PPO)
I understand that beginning on the date AARP® MedicareComplete Choice® plan coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, the plan provides refunds for all covered benefits, even if I get services out-of-network.

AARP® MedicareComplete® Plus (POS)
I understand that beginning on the date AARP® MedicareComplete® Plus plan coverage begins, benefits are available both in and out-of-network, and I understand I must use in-network providers to enjoy the lowest cost sharing. Some non-emergency care from non-contracted providers may not be covered at all under the Point of Service plan. Additionally, some out-of-network services may be limited by county or state and require prior authorization.

Fraud Warning: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an enrollment request form, or files a claim containing a false or deceptive statement, has committed insurance fraud. Commission of insurance fraud may result in disenrollment or denial of benefits and may subject the individual to civil or criminal liability.