Individual Enrollment Request Form

Please contact Trillium Community Health Plan® if you need information in another language or format (Braille).

To Enroll in Trillium Community Health Plan Please Provide the Following Information

Trillium Community Health Plan
PO Box 11756, Eugene, OR 97440
(541) 431-1950 Local
1(800) 910-3906 Toll Free
1(866) 279-9750 TTY
7 Days a Week, 8:00 a.m. - 8:00 p.m.

Please Select Your Trillium Plan Choice

- ☐ Trillium Advantage HMO
- ☐ Trillium Advantage Dual SNP HMO
- ☐ Trillium Advantage Rx HMO
- ☐ Trillium Advantage TLC ISNP HMO
- ☐ Trillium Advantage TLC Community ISNP HMO

Last Name	First Name	M.I.

Sex	Ethnicity	Birth Date	Home Phone	Emergency Phone

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

City	State	Zip Code	County

Mailing Address (if different)

City	State	Zip Code	County

Primary Care Provider (First and Last Name)	Established Patient ☐ Yes ☐ No

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.

Medicare Health Insurance

Sample Only

Name ______________________________

Medicare Claim Number Sex __________

________ - ________ - ________

Is Entitled To Effective Date

Hospital (Part A) ________________

Medical (Part B) ________________

Please Read And Answer These 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.

Your Answers to the Following Questions Will Not Keep You From Enrolling in This Plan:

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 Trillium? ☐ **Yes** ☐ **No**
If yes: Name of other coverage: ____________________

____

ID Number: ________________________________
Group Number: _____________________________

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 of Institution (Number, Street, City, Zip):

____

____

____

Phone Number of Institution: ____________________

____

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**

6) What is the name of your employer? _____________

____

7) Trillium Advantage TLC ISNP and Trillium Advantage Community ISNP members: Do you live in one of the following long-term care facilities?
☐ South Hills ☐ Green Valley
☐ Hillside Heights ☐ Applegate

8) 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 ☐ Large Print ☐ Audio

Please contact Trillium Community Health Plan at 1(800) 910-3906 (TTY users should call 1(866) 279-9750) if you need information in another format or language than what is listed above. Our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week.

Paying Your Plan Premium

Trillium Advantage Dual SNP members: 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, or "Electronic Funds Transfer (EFT)" each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or "Electronic Funds Transfer (EFT)" 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 does not cover.

If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

☐ Get a bill monthly

☐ 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

☐ 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.)

STOP - Please Read This Important Information

If you currently have health coverage from an employer or union, joining Trillium Community Health Plan could affect your employer or union health benefits.

You could lose your employer or union health coverage if you join Trillium Community Health Plan. 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.

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

Trillium Community Health Plan 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: October 15 – December 7 of every year), or under certain special circumstances. Trillium Community Health Plan serves a specific service area. If I move out of the area that Trillium Community Health Plan 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 Trillium Community Health Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Trillium Community Health Plan when I get it to know which rules I must follow in order 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 Trillium Community Health Plan coverage begins, I must get all of my health care from Trillium Community Health Plan, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Trillium Community Health Plan and other services contained in my Trillium Community Health Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **Neither Medicare nor Trillium Community Health Plan 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 Trillium Community Health Plan, he/she may be paid based on my enrollment in Trillium Community Health Plan.

Your Signature Is Required On The Back Of This Form

Please Read And Sign Below

Authorization and Declaration

Release of Information: By joining this Medicare health plan, I acknowledge that Trillium Community 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 Trillium Community Health Plan 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 statues 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 Trillium Community Health Plan or by Medicare.

Your Signature: ______________________________ **Date:** ______________

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

Authorized Representative Signature:______________________________ **Date:** ______________

Address (Number, Street, City, Zip): ______________________________

____

Phone Number: ______________________________

Relationship to Enrollee: ______________________________

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Please mail this original form to:
Trillium Community Health Plan
PO Box 11756
Eugene, OR 97440
or Fax to: (541) 984-5685

For Office and Agent Use Only

Plan ID Number: ______________________

Effective Date of Coverage: ______________

☐ ICEP/IEP ☐ AEP

☐ SEP (type) ☐ Not Eligible

Representative Name (if assisted in enrollment):

____

Broker Name (if assisted in enrollment):

____

Agency Name:

____

Broker Date Stamp: