

Please complete your Group Retiree Election Form with the following information:

Enter the name of the Employer/Trust Group.

1. Plan Information

- Write in the name and facility number of the contracting medical group and Primary Care Physician you have selected. You will find the facility number underneath your physician's name in the Provider Directory.
- If applicable, please select a dentist or dental office from the Dental Directory enclosed in this package. You will find the facility number below the dental office listings.

2. Medical Information

- Please complete the questions about End-Stage Renal Disease (ESRD). ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to maintain life.

3. Personal Information

- Review the Service Area listing in your Provider Directory to ensure you live in the Secure Horizons Medicare Advantage Plan service area.
- Then complete your personal information. If you and your spouse are both enrolling, please complete just one form.
- Complete the Medicare information, which you will find on your red, white and blue Medicare card. Please write your name (last name, first name and middle initial) exactly as it appears on your Medicare card. Your Secure Horizons Medicare Advantage Plan membership card will reflect your name as it appears on your Medicare card.
- Also, if possible, please attach a copy of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board.

4. Don't forget to sign and date your Group Retiree Election Form. (Use a ball-point pen and press hard.)

- You will need to sign this application.
In order to process this application, you must sign the application where indicated.
- If your spouse and/or dependent is included on this application AND he/she is Medicare eligible, he/she must also sign this application where indicated.
- If someone has assisted you in completing this form, that person must also sign this form and indicate his/her relationship to you.
- If a durable Power of Attorney or Legal Guardian/Conservatorship helped you complete this form, he/she must check off the appropriate area, sign and submit a copy of the applicable court order or Durable Power of Attorney that establishes authority to act on behalf of the applicant.

Note: *If you have more than one dependent that you wish to cover, complete and submit an additional Secure Horizons Group Retiree Medicare Advantage Plan Election Form and attach it to this one.*

5. Keep the Member Copy

- Please keep the Member copy of your Secure Horizons Group Retiree Medicare Advantage Plan Election Form. **This will act as your temporary membership card.**
- Remember that your effective date is subject to approval by the Centers for Medicare & Medicaid Services (CMS). Upon confirmation from CMS, PacifiCare will send you written notice of your enrollment effective date.

Incomplete information on this form may delay the processing of your enrollment.

Questions? *Just Ask!*

Arizona and Nevada Customer Service Department
1-800-347-8600 (TTY: 1-800-360-1797)
7 a.m. – 8 p.m., Monday – Friday

California Customer Service Department
1-800-228-2144 (TDHI: 1-800-685-9355)
7 a.m. – 9 p.m., Monday – Friday

Oregon and Washington Customer Service Department
1-800-533-2743 (TTY: 1-800-786-7387)
7 a.m. – 9 p.m., Monday – Friday

Texas and Oklahoma Customer Service Department
1-800-950-9355 (TDHI: 1-800-557-7595)
7 a.m. – 9 p.m., Monday – Friday

Sales Representative
1-800-610-2660 (TDHI: 1-800-387-1074)
6 a.m. – 6 p.m. PST, Monday – Friday

Turn the page to enroll →

3. Personal Information – As it appears on your Medicare card

	Last Name	First Name	M.I.	Sex	Social Security # (Optional)	Birth Date	Telephone
SELF (Retiree)							()
Home Address					City/State/Zip		
Mailing Address					E-mail Address		
Medicare Information	If you have Medicare, what is your Medicare Claim Number?				Part A Effective Date?	___ / ___ / ___	
					Part B Effective Date?	___ / ___ / ___	
If you are currently a resident of an institution (e.g., nursing facility, rehabilitation hospital, etc.), please provide the requested information on the next two lines. Providing this information will not affect your eligibility to enroll in the Medicare Advantage Plan.							
Institution Name	Date of admission			/	/	Telephone # ()	
Address							
SPOUSE							()
Home Address					City/State/Zip		
Medicare Information	If you have Medicare, what is your Medicare Claim Number?				Part A Effective Date?	___ / ___ / ___	
					Part B Effective Date?	___ / ___ / ___	
If you are currently a resident of an institution (e.g., nursing facility, rehabilitation hospital, etc.), please provide the requested information on the next two lines. Providing this information will not affect your eligibility to enroll in the Medicare Advantage Plan.							
Institution Name	Date of admission			/	/	Telephone # ()	
Address							
DEPENDENT #1							()
Home Address					City/State/Zip		
Medicare Information	If you have Medicare, what is your Medicare Claim Number?				Part A Effective Date?	___ / ___ / ___	
					Part B Effective Date?	___ / ___ / ___	
If you are currently a resident of an institution (e.g., nursing facility, rehabilitation hospital, etc.), please provide the requested information on the next two lines. Providing this information will not affect your eligibility to enroll in the Medicare Advantage Plan.							
Institution Name	Date of admission			/	/	Telephone # ()	
Address							

4. ATTENTION! Please sign and date

My signature below warrants that I have read and understand this Group Retiree Election Form, including the Statement of Understanding, and that the information provided by me is accurate and complete. I understand that as a member of the Medicare Advantage Plan, I have the right to appeal service and payment denials made by PacifiCare. **I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE [DBA SECURE HORIZONS] OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.** This form represents my temporary Secure Horizons Group Retiree Medicare Advantage Plan membership card.

You must sign and date this Election Form in order for it to be processed.

If signed by an authorized representative of the member, 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 PacifiCare or by Medicare.

Effective Date

Retiree's Signature

Date

Spouse's Signature

Date Dependent's Signature

Date

Signature of Individual Who Assisted in Completing This Form

Date

Relationship to Applicant

If Durable Power of Attorney or Legal Guardian/Conservatorship, indicate here and attach applicable court order or Durable Power of Attorney that establishes authority to act on behalf of the applicant.

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

Name

Address

Telephone Number

Relationship to Applicant

Statement of Understanding

I understand that beginning on my effective date as a Secure Horizons Group Retiree Medicare Advantage (MA) Plan member, all medical services, with the exception of emergency, urgently needed services, or out-of-area dialysis must be provided or arranged for by PacifiCare contracting providers. Services rendered without prior authorization of my PacifiCare contracting primary care physician (PCP), except for emergency services anywhere in the world or urgently needed services outside the Secure Horizons MA Plan service area (or under unusual and extraordinary circumstances, provided when I am in the service area, but my contracting medical group is temporarily unavailable or inaccessible), will not be reimbursed by PacifiCare or Medicare.

I understand that since I can be a member of only one MA Plan at any one time, I cannot enroll in more than one MA Plan with the same effective date of coverage. If I do this, my enrollments will be canceled and I will have to fill out a new Election Form to become a member of a MA Plan. By enrolling in Secure Horizons Group Retiree MA Plan, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS) from any other Medicare Advantage Plan of which I may be a member. It is my responsibility to inform PacifiCare of any prescription drug coverage that I have or may get in the future.

By enrolling in the Secure Horizons MA Plan, I authorize CMS to provide information to PacifiCare, confirming my entitlement to Medicare Hospital Insurance Benefits (Part A) and enrollment for Supplementary Medical Insurance Benefits (Part B) under Title XVIII (the Medicare Program) of the Social Security Act. I understand I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premiums. I also authorize PacifiCare contracting providers or any other holder of medical or other relevant information about me to release to CMS or CMS's agents any information needed to administer Title XVIII of the Social Security Act.

I HEREBY AUTHORIZE any person, including, but not limited to, physicians, hospitals, insurance companies and other organizations, to release any information acquired by such person in the course of examination or treatment of myself, that is relevant to the provision of or coordination of benefits or professional review activities.

As a Secure Horizons Group Retiree MA Plan member, I understand that I am bound by the benefits, copayments, exclusions, limitations and other terms of the Secure Horizons Group Retiree MA Plan Evidence of Coverage (EOC) and Retiree Benefits Summary.

It is my responsibility to read the Evidence of Coverage document from PacifiCare when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage Plan. If you have not received your EOC, please call your Sales Representative/Benefits Administrator and request a copy.

I agree and understand that any differences between myself and PacifiCare, relating to the Health Plan or its performance, are subject to arbitration in accordance with the rules of the Arbitration Association designated by PacifiCare. By acceptance of this request for coverage, PacifiCare shall be bound by the terms of the Secure Horizons MA Plan Evidence of Coverage. Arbitration does not apply to disputes subject to the CMS appeals process. I understand that as a member of the MA Plan, I have the right to appeal service and payment denials made by PacifiCare.

I understand that it is my responsibility to inform PacifiCare prior to moving or leaving the service area for more than six (6) consecutive months, and that my absence means PacifiCare may take action to disenroll me from Secure Horizons Group Retiree MA Plan and return me to Original Medicare coverage.

I understand my election to enroll in the Secure Horizons Group Retiree MA Plan will be effective the first day of the month following the month in which I submit my completed and signed election form, unless my employer's health plan coverage or my Medicare entitlement goes into effect at a later date. For more information on election periods, I can call PacifiCare at the number listed. If my eligibility in Secure Horizons Group Retiree MA Plan is not approved by CMS, I am financially responsible for all medical services rendered as of the date of this application. I understand that upon confirmation from CMS, PacifiCare will send me written notice of my effective date. Until I have received this written notification, I should not drop any supplemental insurance I have in effect now.

As of my enrollment effective day in the Secure Horizons Group Retiree MA Plan, all of my routine health care must be provided for by PacifiCare contracting medical providers.

Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances. I understand that I can disenroll from the Secure Horizons Group Retiree MA Plan by calling 1-800-MEDICARE (TTY users should call 1-877-486-2048) 24 hours a day, 7 days a week, or by sending a written request to my benefits administrator or PacifiCare. Until the effective date of disenrollment, I must continue to receive routine covered services from PacifiCare contracting providers. PacifiCare will send me a letter confirming the effective date of my disenrollment.

I understand that if I disenroll from this employer-sponsored Medicare Advantage Health Plan, I will be automatically transferred to the Original Medicare Plan (fee-for-service program). Also, I understand that if I choose to enroll in a non-employer-sponsored Medicare Advantage Health Plan, or another employer-sponsored Medicare Advantage Health Plan, I will be automatically disenrolled from this employer-sponsored Health Plan.

MEMBER: This form represents your temporary Secure Horizons Group Retiree Medicare Advantage Plan membership card. Please keep it with you and present it each time you require services from a PacifiCare contracting provider. If you do not receive your permanent card within 30 days of your effective membership date, please call the Customer Service numbers listed on the instruction sheet.

PROVIDER: When presented with this temporary membership card, please have member sign ELIGIBILITY GUARANTEE FORM if you do not receive verbal/written eligibility from PacifiCare.