Health Pointe of New York

Official Use Only

Name of staff member/agent/broker (if assisted in enrollment): Rep ID:

Plan ID: Effective Date of Coverage:

ICEP/IEP OEP AEP SEP (type):

1-844-269-3442 or TTY 711 • Monday-Friday from 8:00 AM through 8:00 PM
Health Pointe Direct Complete Plan (HMO I-SNP) Enrollment Form
Please contact Health Pointe Complete Plan if you need information in another language or format.

To Enroll in Health Pointe Complete Plan, please provide the following information:

Last Name:	First Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (MM / DD / YYYY)	Sex: ☐ M ☐ F	Home Phone Number: Alternate Phone Number:	

Permanent Residence Street Address: (P.O. Box is not allowed)
Street Address:
City: State: Zip Code:

Mailing Address (only if different from your Permanent Residence Address):
Street Address:
City: State: Zip Code:

Emergency Contact Name: Phone Number: Relationship to you:

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 Social Security or the Railroad Retirement Board

You must have Medicare Part A and Part B to Join a Medicare Advantage Plan.

Name (as it appears on your Medicare card): _____

Medicare Number: _____

Is Entitled To: Effective Date:
HOSPITAL (Part A) _____
HOSPITAL (Part B) _____

You must have Medicare Part A and Part B to Join a Medicare Advantage Plan.

Paying Your Plan Premium

You can pay your monthly plan 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.

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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 Health Pointe Direct Complete Plan 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 only pays 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 bill each month.

Please select a premium payment option:

☐ Get a bill each month

☐ 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. 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.

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 Health Pointe Direct Complete Plan?

☐ 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:

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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 & Phone Number of Institution (number and street): _____
_____

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

Please choose the name of a Primary Care Physician (PCP), clinic or health center:

_____

Are you already a patient of this PCP? ☐ Yes ☐ No

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 ☐ Russian ☐ Chinese ☐ Korean ☐ Audio tape, large print

Please contact Health Pointe at 1-844-269-3442 if you need information in another format or language than what is listed above. Our office hours are 8 am to 8 pm Monday-Friday. TTY users should call 711.
Please check one of the boxes below to select your primary (spoken) language if other than English:

☐ Spanish ☐ Russian ☐ Chinese ☐ Korean ☐ Unknown ☐ Declined

If you currently have health coverage from an employer or union, joining Health Pointe Direct Complete Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Health Pointe Direct Complete 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.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:
Health Pointe Direct Complete 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.

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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.

Health Pointe Direct Complete Plan serves a specific service area. If I move out of the area that Health Pointe Direct Complete 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 Health Pointe Direct Complete 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 Health Pointe Direct Complete Plan when I get it to know which rules I must follow 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 Health Pointe Direct Complete Plan coverage begins, I must get all of my health care from Health Pointe Direct Complete Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Health Pointe Direct Complete Plan and other services contained in my Health Pointe Direct Complete Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH POINTE DIRECT COMPLETE 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 Health Pointe Direct Complete Plan, he/she may be paid based on my enrollment in Health Pointe Direct Complete Plan. Release of Information: By joining this Medicare health plan, I acknowledge that the Health Pointe Direct Complete Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Pointe Direct Complete 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 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.

Signature: Today's Date:

If you are the authorized representative, you must sign above and provide the following information:
Name:
Address:
Phone Number: ( ) -
Relationship to Enrollee:

If you are a translator or witness to the enrollment, please provide the following information:
Name:
Address:
Phone Number: ( ) -
Relationship to Enrollee:

Licensed Sales Representative:_____ Initial Received Date:

Heath Pointe Direct Complete Plan (HMO I-SNP) Complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national orgin, age, disability, or sex.
Health Pointe Direct Complete Plan (HMO I-SNP) cumple con las leyes federales de derechos civiles aplicables y nodiscrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Health Pointe Direct Complete Plan (HMO I-SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Health Pointe Direct Complete Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Health Pointe Direct Complete Plan provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Health Pointe Direct Complete Plan provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact the Customer Care Center at 1-844 269-3442.

If you believe that Health Pointe Direct Complete Plan (HMO I-SNP) has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. If you need help filing a grievance, The Grievance Department is available to help you. You can file a grievance in person or by mail, fax, or email:

Grievance Department
810 7th Ave, Suite 801
New York, NY 10019
Phone: 1-844-269-3442
Email: Grievance@healthpointeny.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-844-269-3442 (TTY 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-269-3442 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电1-844-269-3442 (TTY 711). 我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電1-844-269-3442 (TTY 711). 我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-269-3442 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-269-3442 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương trình sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-844-269-3442 (TTY 711). Sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-269-3442 (TTY 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화1-844-269-3442 (TTY 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-269-3442 (TTY 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. سيقوم شخص ما يتحدث24439624481للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على. مبساعدتك. هذه خدمة مجاني ةلاعربية.

Hindi: हमारे स्वास्थ्य या दवा की योजना केबारे में आपकेकिसी भी प्रश्न केजवाब देने केलिए हमारे पास मुफ्त दुभाषिया सेवाएँउपलब्ध हैं. एक दुभाषिया प्राप्त करने केलिए, बस हमें 1-844-269-3442 (TTY 711). पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-844-269-3442 (TTY 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-269-3442 (TTY 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-269-3442 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-269-3442 (TTY 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-844-269-3442 (TTY 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。