



If you are changing options within Health First Medicare Plans you should use this form.
This form may not be used to enroll in Health First Medicare Plans for the first time.

Personal information

Name _____

Member number _____

Permanent Address _____

City _____ State _____ Zip _____

Telephone _____

Mailing Address (if different) _____

City _____ State _____ Zip _____

Select your option

I would like to change my plan option to the one indicated below. I understand that this option has different health benefits and a different monthly premium, and my new plan will generally be effective the first day of the month after Health First Health Plans receives this form. If you qualify for extra help with your Medicare prescription drug costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

Select your plan:	Monthly premium	PCP visit	Specialist visit	Emergency visit	Urgent care	Out-of-pocket maximum	Part D drugs
____ Premier	\$96.00	\$10	\$25	\$50	\$10	\$3,100	Included
____ Classic	\$67.00	\$10	\$25	\$50	\$10	\$3,100	Included
____ Value	–None–	\$10	\$30	\$50	\$10	\$3,100	Included
____ Secure	\$39.00	\$10	\$25	\$50	\$10	\$3,100	–None–
____ Sunshine*	Varies*	\$10	\$20	\$50	\$10	\$2,000	Included

* Sunshine is only for people with Medicare and Medicaid. Premium is based on the individual low-income subsidy.

Release of Information

As a member of this plan, I allow the Centers for Medicare & Medicaid Services (CMS) to give information to the plan. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B). I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give CMS or CMS's agents the information needed to run the Medicare program.

Please read and sign below

I understand that, beginning on the date my Medicare Advantage plan coverage begins for my new option, I must continue to get all of my health care from my Medicare Advantage plan, with the exception of emergency or urgently needed services or out-of-area dialysis services. In addition to being covered in the United States, emergency and urgently needed services are covered in hospitals worldwide. I understand that services authorized by the Medicare Advantage plan and other services contained in my Medicare Advantage plan Evidence of Coverage document will be covered. I also understand that without authorization, NEITHER MEDICARE NOR THE MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES.

I understand that my signature on this form means that I have read and understand the contents of this form.

(Please read your Evidence of Coverage document to know what rules you must follow in order to receive coverage and during what times you are eligible to make an election change with this Medicare Advantage plan.)

Enrollee's Signature* _____ Date _____

*If the individual is unable to sign, a court-appointed Legal Guardian or person with Durable Power of Attorney for Health Care (DPAHC), if authorized by state law, must sign the following line. Attach a copy of the proof of Legal Guardian, DPAHC, or proof of authorization by state law.

Signature _____ Date _____

*If anyone helped the beneficiary fill out this form, s/he must sign the following line:

Signature _____ Date _____

Relationship to beneficiary _____

Payment information

If you're changing from a plan with *no* premium to a plan *with* a premium, or to a plan with a higher premium, you have several choices of how to pay the premium each month. Please select one of the payment options below (if you don't select one, you'll receive a coupon book):

I would like my premium to be automatically charged to my credit card each month:

__MasterCard __Visa __Discover __American Express Card # _____

Name on credit card (please print) _____ Exp. date _____

I authorize Health First Health Plans to charge my monthly premium to the above credit card on or around the 5th business day of each month to cover that month's premium. This authorization will remain in force as long as my membership is active in a plan requiring a premium, or until I cancel or change this request. This option will continue even if the amount of my premium changes. I understand I must provide 30 days advance notice before changes to this payment option can be made, unless my membership with Health First Health Plans ends and/or premium payments are no longer due.

Signature _____ Date _____

I would like to set up electronic funds transfer (EFT) to automatically make payments from my checking account each month. I have attached a check for my first month's premium, and authorize HFHP and my financial institution to initiate debit entries or corrections for future months from the account on this check.

Signature _____ Date _____

Please send me a book of coupons I can return to HFHP with my check or money order each month.

I have enclosed a check or money order for my first month's premium.

I would like to pay by credit card for one month only. Please send me a book of coupons I can return to HFHP with my check or money order each month after that.

__MasterCard __Visa __Discover __American Express Card # _____

Name on credit card (please print) _____ Exp. date _____

Signature _____ Date _____

Automatically deduct the monthly premium for this Medicare plan from my Social Security check.

The SSA deduction may take two or more months to begin, and in most cases, the first deduction will include all premiums due from my enrollment effective date up to the point withholding begins.

Please mail this form (and payment if applicable) to Health First Health Plans, Attn. Group Services, 6450 US Highway 1, Rockledge, FL 32955. Do not send cash in the mail.

Office Use Only: Senior Consultant's signature _____

Date received _____ Proposed effective date _____

Plan ID# _____ Payment: __Check (# _____) __Money order __Credit card

__ICEP/IEP __OEP __AEP __SEP (type) _____