

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee: _____

Signature: _____ National Producer Number (Agents/Brokers only): _____

Complete as appropriate

Monthly Payment Method: Automatic Bank Withdrawal Coupon Book

First month premium collected: Amount \$ _____ Check # _____

I want to receive the Annual Notice mailing by: Email Print

I want plan information sent in a language other than English.

Language _____

I want plan information sent in an accessible format:

Large Print Audio CD Data CD Other _____

Contact Member Services at 1-866-821-1365 if you need information in an accessible format or language other than what is listed above. Office hours are M-F, 8:00am to 5:00pm, CST. TTY users call 1-800-735-2942.

By completing this enrollment application, I agree to the following: Medical Associates Health Plans, Inc (MAHP) is a Medicare COST plan and I will need to keep my Medicare Part B. I can be in only one Medicare Health plan at a time. I know I may disenroll from this MAHP plan at any time by sending a written request to MAHP or by calling I-800-Medicare (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

MAHP serves a specific service area. If I move out of the area that MAHP serves, I need to notify MAHP so I can disenroll and find a new plan in my new area. Once I am a member of MAHP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from MAHP when I receive it to know which rules I must follow in order to receive coverage with this MAHP plan.

I understand that beginning on the date MAHP coverage starts, in order for MAHP to fully cover my medical services (except for emergency or urgently-needed services), all of my health care must be provided or arranged by MAHP. If I obtain services not provided or arranged by MAHP, I will be responsible for all Medicare deductibles and coinsurance, MAHP copayments, as well as any additional charges as prescribed by the Medicare program. I may also be liable for charges not covered by Medicare.

Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico. Services authorized by MAHP and other services contained in my MAHP Evidence of Coverage document will be covered.

Each year MAHP is required to send you the Annual Notice of Changes (ANOC) and Evidence of Coverage (EOC) documents describing the changes to your coverage. You can elect to receive these documents electronically to your personal email address. If you initially select the electronic delivery, you can request the printed materials at any time.

Release of information: By joining this MAHP plan, I acknowledge that MAHP will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. 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 MAHP plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under State law 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 MAHP or by Medicare.

Mailing address: Medical Associates Health Plans (MAHP), 1605 Associates Drive, Suite 101, Dubuque, Iowa 52002