IBEW Local 38 Health & Welfare
Phone: 216-431-7738 | Fax: 216-431-7719

MEDICARE ADVANTAGE PLAN ENROLLMENT REQUEST FORM

Proposed Effective Date of Coverage: MM / DD / YYYY

1. Applicant Information:

Last Name ____________ First Name ____________ Gender M / F ____ Birth Date ____________

Cell Phone ____________ Home Phone ____________ Email ____________

Race:

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ White
- ☐ I choose not to answer

Ethnicity:

- ☐ Hispanic or Latino Origin
- ☐ Not Hispanic or Latino Origin
- ☐ I choose not to answer

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

City ____________ State ____________ Zip code ____________

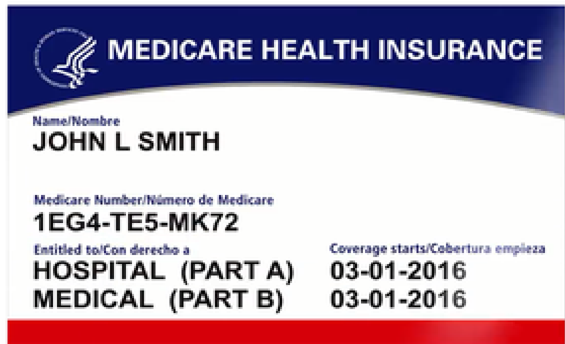
Mailing Address **(Only if it is different then the above. P.O. Box is allowed):** ____________

City ____________ State ____________ Zip code ____________

2. Medicare Information:

You are required to have Medicare Part A and Medicare Part B to join a Medicare Advantage Plan.

ATTACH A COPY OF YOUR RED, WHITE, AND BLUE



PLEASE NOTE, APPLICATION IS *NOT VALID* UNLESS MEDICARE CARD IS ATTACHED.

OVER

3. A few questions to help manage your plan:

1.) Once enrolled, will you have other Health Coverage **in addition to our plan?** ☐ **NO** ☐ **YES**

Name of Secondary Medical Coverage: ____________ Group Number : ____________ Member ID for Coverage: ____________

Some individuals may have other drug coverage, including other private insurance, TRICARE, Worker's Compensation, federal employee health benefits, VA Benefits, or State Pharmaceutical Assistance programs.

2.) Will you have other Prescription Drug Coverage **in addition to our plan**? ☐ **NO** ☐ **YES**

Name of Secondary RX Coverage: ____________ Member ID : ____________ Group Number : ____________ RX Bin: ____________

3.) Do you have End-Stage Renal Disease (ESRD)? ☐ **NO** ☐ **YES**

3. Signature and Date

I understand that my signature on this Enrollment Request Form means that I have read and understood the contents of this Enrollment Request Form, and that the information provided by me is accurate and complete. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. **This Enrollment Request from must be signed, dated and received prior to your desired effective date with a copy of your Medicare Card.** Upon receipt, the plan will process the form according to Medicare guidelines**.**

Signature of Applicant/Authorized Representative: ____________

Todays Date: **MM / DD / YYYY**

Authorized Representative Information:

If you are an authorized legal representative, you ***must sign above*** and provide the following information below. By signing above, you are confirming you have the legal right under state law to sign and can show written proof of this right if Medicare should ask for it.

Last Name: ____________ First Name: ____________

Relationship to Applicant: ____________ Phone Number: ____________

Address: ____________

City: ____________ State: ____________ Zip code: ____________ County: ____________

RETURN THIS COMPLETED FORM BY MAIL, FAX OR EMAIL TO:

I.B.E.W Local No. 38 Health & Welfare
P.O. Box 6326
Cleveland, OH 44101-1326
Fax: 216-431-7719
Email: Tammy@ibew38-benefits.com