

IBC/AmeriHealth 2014 New Business Coversheet

Agent Name: RAFIK GHAZAL Writing Number: 14586936
Member Name: VERONICA GRECO

Scope of Appointment Determination:

Is Paper SOA Attached

YES	Check boxes that apply:	NO	Check one:
Face to Face IBC/AHNJ Provided Preset Appointment resulting in sale to spouse or guest.		Face to face IBC/AHNJ Provided Preset Appointment resulting in Sale.	
Self-generated Face to Face Appointment resulting in sale.	✓	Informal Sales Event: Location: Date:	
Same Day Scope of Appointment: ****Provide detailed explanation as to why the app was taken on the same day on the SOA.		Formal Sales Event: Location: Date:	
Additional Comments :		Sales Kit Mailed to Beneficiary: (NO FACE TO FACE) (Circle One if applicable) App faxed back to agent App emailed back to agent.	

Fax OR Email Cover Sheet, Application, and Paper Scope of Appointment (if applicable) to:

Fax: 866-904-5118

Email: biz@ritterim.com

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AmeriHealth 65 HMO

A Medicare Advantage Plan from AmeriHealth H&G, Inc.

INDIVIDUAL ENROLLMENT NON-GROUP ELECTION FORM

Please contact AmeriHealth 65® Preferred HMO if you need information in another language or format (Braille).

A To Enroll in AmeriHealth 65 Preferred HMO, Please Provide the Following Information:

Please check which plan you wish to enroll in:

AmeriHealth 65 Preferred HMO Plan	Region 1 (032) Ocean County	Region 2 (029 and 030) Burlington, Camden, Cumberland, Gloucester, Salem, Mercer, Hunterdon, Somerset, Union, Essex, Hudson counties	Region 3 (033 and 034) Atlantic, Monmouth, Warren, Morris, Bergen counties
Medical Only (No Rx)	Monthly Premium N/A	Monthly Premium \$15.00	Monthly Premium \$30.00
Medical with Rx	\$0.00	\$39.00	\$69.00

You must continue to pay your Medicare Part B premium.

AmeriHealth HMO, Inc. is an HMO plan with a Medicare contract. Enrollment in AmeriHealth HMO, Inc. depends on contract renewal.

LAST Name: GRECO	FIRST Name: VERONICA	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input checked="" type="checkbox"/> Ms.
Birth Date: (08/21/1949) (M M / D D / Y Y Y Y)	Sex: <input type="checkbox"/> M <input checked="" type="checkbox"/> F	Home Phone Number: (856) 834-8769	
Permanent Residence Street Address (P.O. Box is not allowed): 17 EATON CIR			
City: CLEMENTON	State: NJ	ZIP Code: 08021	

Mailing Address (only if different from your Permanent Residence Address):

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Emergency Contact: _____

Phone Number: _____ **Relationship to You:** _____

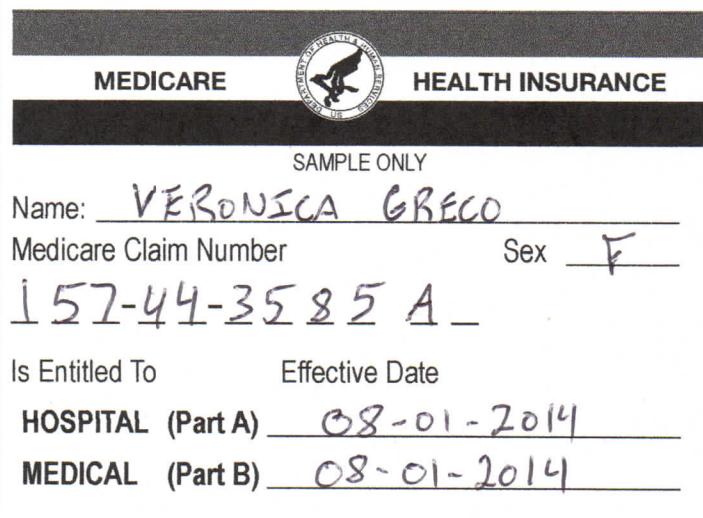
E-mail Address: _____

B Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white, and blue 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.



C**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 or Electronic Funds Transfer (EFT) 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.

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 AmeriHealth 65 Preferred HMO 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 pays only 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
 Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: _____

Account type: Checking

Saving

Bank account number: _____

- Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (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.)

D**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 AmeriHealth 65 Preferred HMO? 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: _____

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 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:

Other language (please specify) _____
 Braille or audio tape _____

Please contact AmeriHealth 65 Preferred HMO at 1-800-898-3492 if you need information in another format or language than what is listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. TTY users should call 1-877-219-5457. However, please be aware that on weekends and holidays from February 15 through September 30, your call may be sent to an answering machine.

Por favor, póngase en contacto con AmeriHealth 65 Preferred HMO al 1-800-898-3492 si necesita información en español o en algún idioma además que aparece arriba.

E**Please choose your providers**Primary Care Physician (check box if current physician)

Physician Code No.

DR. ANTHONY BONETT

0 5 6 6 6 7 1 0 0 1

The 10-digit number beneath provider name in directory

F**Attestation of Eligibility for an Enrollment Period**

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare.
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____.
- I am moving into, live in, or recently moved out of a Long Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.
- I recently left a PACE program on (insert date) _____.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- I am leaving employer or union coverage on (insert date) _____.
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a Special Needs Plan (SNP), but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

If none of these statements applies to you or you're not sure, please contact AmeriHealth 65 Preferred HMO at 1-800-898-3492 (TTY users should call toll-free 1-877-219-5457) to see if you are eligible to enroll.

**Please Read This Important Information**

If you currently have health coverage from an employer or union, joining AmeriHealth 65 Preferred HMO could affect your employer or union health benefits. You could lose your employer or union health coverage if you join AmeriHealth 65 Preferred HMO. 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.

By completing this enrollment application, I agree to the following:

AmeriHealth 65 Preferred HMO 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 only be in 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. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. 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.

AmeriHealth 65 Preferred HMO serves a specific service area. If I move out of the area that AmeriHealth 65 Preferred HMO 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 AmeriHealth 65 Preferred HMO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from AmeriHealth 65 Preferred HMO when I get it to know which rules I must follow in order 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 AmeriHealth 65 Preferred HMO coverage begins, I must get all of my health care from AmeriHealth 65 Preferred HMO, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by AmeriHealth 65 Preferred HMO and other services contained in my AmeriHealth 65 Preferred HMO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR AMERIHEALTH 65 PREFERRED HMO 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 AmeriHealth 65 Preferred HMO, he/she may be paid based on my enrollment in AmeriHealth 65 Preferred HMO.

Release of Information: By joining this Medicare health plan, I acknowledge that AmeriHealth 65 Preferred HMO will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that AmeriHealth 65 Preferred HMO 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.

Benefits underwritten or administered by AmeriHealth HMO, Inc.

Signature:

Today's Date:

6/25/2014

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: (____) ____ - ____

Relationship to Enrollee: _____

Office Use Only

Name of agent/broker (if assisted in enrollment):

RAFIK GHAZAL

Agent/broker signature:

Date application received: 6/25/14

Plan ID #: H3156-030-000

Effective Date of Coverage: 8/1/2014

ICEP/IEP:

AEP: _____ SEP (type): _____

Not Eligible: _____

Agent Number (NIPR/NPN) 14586936

General Agency Number _____

FMO ID 1001

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.

Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.



Medicare Advantage Plans (Part C) and Cost Plans

Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.

Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

Ancillary Products – Dental/Vision/Hearing

Plans that provide coverage for dental, vision or hearing. These plans are not affiliated or connected to Medicare.

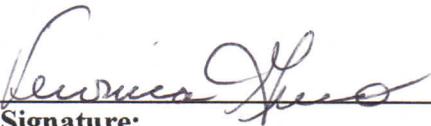
Medicare Supplement Products

A Medicare Supplement, or Medigap, plan helps pay some of the health care costs, like copayments, coinsurance and deductibles, that Original Medicare doesn't cover. Medicare will pay its share of the Medicare-approved amount for covered health care costs, then your Medigap policy pays its share. With a Medigap plan you may go to any Medicare-approved doctor, hospital and provider. A Medigap plan does not cover outpatient prescription drugs.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:



Signature:

6/10/2014

Signature Date:

If you are the authorized representative, please sign above and print below:

Representative's Name: _____

Your Relationship to the Beneficiary: _____

2 of 3

Y0041_HNS_13_7480

To be completed by Agent:

Agent Name: <i>RAFIK GHAZAL</i>	Agent Phone: <i>856-577-3467</i>
Beneficiary Name: <i>VERONICA GRECO</i>	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Initial Method of Contact: <i>BENEFICIARY CALLED TO REQUEST INFO FOR AMERIHEALTH</i> (Indicate here if beneficiary was a walk-in.)	
Agent's Signature: <i>Rafi G</i>	
Plan(s) the agent represented during this meeting: <i>AH 65 HMO</i>	
Date Appointment Completed: <i>6/25/2014</i>	
[Plan Use Only:]	

Scope of Appointment documentation is subject to CMS record retention requirements

ATTENTION AGENTS

CMS requires that Scope of Appointment Forms are completed a minimum of 48 hours prior to the appointment. If this Scope of Appointment Form was completed less than 48 hours before the appointment, you must provide an explanation of the extenuating circumstance here:

AmeriHealth HMO, Inc. is a Medicare Advantage organization with a Medicare contract.