

Medicare Advantage Plan Election Form

Please fill in all information requested. Be sure to read the back of this form.

Retiree/Spouse Information	Social Security Number		Last Name (as appears on Medicare card)		First Name Middle Initial		Home Phone ()	
	Permanent Residential Address				<input type="checkbox"/> Male	Date of Birth (Mo/Day/Yr)		(Mo/Day/Yr)
					<input type="checkbox"/> Female	/ /	<input type="checkbox"/> Married	/ /
	City		State	ZIP Code +4		County (Residence)		Medical/Dental Effective Date (Mo/Day/Yr)
Mailing Address (if different than above)			City		State	ZIP Code +4		County (Residence)
Retiree	Relationship SPOUSE	Last Name		First Name Middle Initial		Social Security Number		Date of Birth (Mo/Day/Yr)
							/ /	
Permanent Residential or Mailing Address (if different from above)				City			State	ZIP Code +4

Medicare Retiree	Retiree Name _____				Spouse	Spouse Name _____					
	Medicare Claim Number _____ - _____ - _____					Medicare Claim Number _____ - _____ - _____					
	Is entitled to	Effective Date		Effective Date		Is entitled to	Effective Date		Effective Date		
Hospital (Part A)		/ /	Medical (Part B)		/ /	Hospital (Part A)		/ /	Medical (Part B)		/ /

PCP and Plan Choice	I wish to enroll in:				I wish to enroll in:			
	Group Health Cooperative <input type="checkbox"/> Group Health Medicare Advantage Classic <input type="checkbox"/> Group Health Medicare Advantage Value				<input type="checkbox"/> DeltaCare, administered by Washington Dental Service Dentist or clinic code _____			
	Kaiser Foundation Health Plan of the Northwest <input type="checkbox"/> Kaiser Permanente Classic <input type="checkbox"/> Kaiser Permanente Value				<input type="checkbox"/> Uniform Dental Plan			
	PacifiCare of Washington, Inc. <input type="checkbox"/> Secure Horizons Classic <input type="checkbox"/> Secure Horizons Value				<input type="checkbox"/> Willamette Dental of Washington, Inc. Clinic location _____			
I wish to cancel my current medical coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No								

Retiree	Name of Contracting Primary Care Physician (PCP) (refer to Provider Directory) _____				Spouse	Name of Contracting Primary Care Physician (refer to Provider Directory) _____			
	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No					Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Medical Information	1. Do you currently have end-stage renal disease (kidney disease)? Retiree: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you currently a member of PacifiCare of Oregon/Washington? Retiree: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No				Note: Your answers to questions #3 and #4 below will not affect your eligibility to enroll in a Medicare Advantage plan.			
	2. Do you have any health insurance other than Medicare? Retiree: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, through which company? _____ What type of policy? _____ Do you intend to discontinue this policy? Retiree: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No				3. Do you live in an institution? Retiree: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of institution _____ Address _____ Phone number _____ Date of admission _____			
	4. Are you currently receiving Medicaid? Retiree: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Medicaid #: _____							

Signature and Authorization continued on back

