## Instructions for Completing the Advantra® Freedom Enrollment Application

Use the instructions below to help you to complete your Advantra Freedom Enrollment Application. Tear these instructions out of this booklet on the perforated line so you can lay out the instructions next to the application as you are filling it out. Match the numbered items below with the bracketed numbers on the Enrollment Application.

- ➜ Read and complete all the steps of the application in black or blue ink.
- ➜ Keep a copy of the application for your records.
- ➜ If you have any additional questions regarding how to enroll, or how to complete this enrollment application, please call an Advantra Freedom representative at 1-800-711-1607 or TDD for the hearing impaired at 1-866-386-2335, Monday through Friday from 8:00 a.m. to 11:00 p.m., Eastern Standard Time. From November 15, 2006 to March 1, 2007, representatives are available from 8:00 a.m. to 11:00 p.m., Eastern Standard Time, 7 days a week, including holidays.

**1)** LAST Name, FIRST Name: MIDDLE Initial: Write your Last name, First name and the initial of your MIDDLE name in the box.

**2)** Title: Check off your title. Choose from Mr., Ms., or Mrs.

**3)** Marital Status: Place a check mark in front of the letter that describes your Marital Status. S=Single, M=Married, D=Divorced, W=Widowed

**4)** Birthdate: Write the month, day and year you were born.

**5)** Sex: Check in the box whether you are a Male or Female.

**6)** Social Security Number: Write your 9 digit Social Security Number on the lines.

**7)** Home Phone Number: Write your 10 digit home phone number.

**8)** Permanent Resident Street Address: Write the street address where you live full time.

**9)** City: Write the city/town where you live full time.

**10)** County: Write the county where you live full time.

**11)** State: Use the 2-digit state abbreviation where you live full time.

**12)** Zip Code: Your 5 digit zip code where you live full time.

**13)** Mailing Address: If your mail is delivered at a different address than your actual street address where you live, such as a P.O. Box number, please fill in the box.

**14)** City: Write the city/town where your mail is delivered.

**15)** County: Write the county where your mail is delivered.

**16)** State: Write the 2-digit state abbreviation where your mail is delivered.

## Instructions for Completing the Advantra Freedom Enrollment Application *(cont.)*

**17)** Zip Code: Write the 5-digit zip code where your mail is delivered in the box.

**18)** Emergency Contact: Write the name of the person who will be your emergency contact, their phone number and relationship to you. For example, your emergency contact could be your daughter.

**19)** Email Address: This is an optional field. Provide your email address on the line. Your email address will be used to send you important announcements about Advantra Freedom. Your email address will not be shared with anyone outside of Coventry Health Care, Inc.

**20)** Select one Benefit Plan by placing a check mark in the box of the plan you would like to enroll in.

**21)** Take out your Medicare Card and carefully fill in the blank lines so your enrollment form's Medicare card matches the information on your actual card. If you have not received your card from Medicare yet, attach a copy of your letter from the Social Security Administration or Railroad Retirement Board.

**22)** You have 3 choices to pay your monthly premium. Choose one payment option ONLY by placing a check mark in the box.

**23)** Answer each question. Either place a check mark in the Yes or No box or write your answers on the lines provided.

**24)** Read "This important information" section carefully.

**25)** Read the information and then sign your name. If you are an authorized representative completing the application, you need to sign your name. Write today's date in the box.

**26)** If you are an authorized representative, write your name, phone number, address and relationship to enrollee.

**27)** If you are the Agent/Producer/Broker, please provide your name, Distribution Partner, Agent/Producer ID#, Alternate Payee Number: Telephone #, Application Receipt Date By Agent and sign your name.

*Once your Advantra Freedom application is completed, send it in by one of these methods:*

| | | | |
|---|---|---|---|
| MAIL the Completed Application(s) to:<br>Advantra Freedom Enrollment<br>Coventry Health Care Plan<br>3721 TecPort Drive<br>P.O. Box 67103<br>Harrisburg, PA<br>17016-9952 | **OR**, Give the completed application to your agent for processing | **OR**, Fax the Completed Application(s) to:<br>Advantra Freedom<br>Attention:<br>Enrollment Department<br>1-866-415-2232 | **OR**, Enroll Online on our Website at<br>www.advantrafreedom.com<br>Or CMS Website at:<br>www.medicare.gov. |

Advantra® Freedom

# ADVANTRA® FREEDOM Individual Enrollment Application

**Step 1**
**TO ENROLL IN ADVANTRA FREEDOM, PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT YOU:**

| (1) LAST name: | FIRST name: | Middle Initial: | (2) ❒ Mr. ❒ Ms. ❒ Mrs. | (3) Marital Status ❒ S ❒ M ❒ D ❒ W |
|---|---|---|---|---|
| | | | | |

| (4) Birth Date: (_____/_____/_____) ( MM / DD / YYYY ) | (5) Sex: ❒ Male ❒ Female | (6) Social Security Number: __ __ __ - __ __ - __ __ __ __ | (7) Home Phone Number: (__ __ __) __ __ __ - __ __ __ __ |
|---|---|---|---|
| | | | |

(8) Permanent Residence Street Address:

| (9) City: | (10) County: | (11) State: | (12) ZIP Code: |
|---|---|---|---|
| | | | |

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

| (14) City: | (15) County: | (16) State: | (17) ZIP Code: |
|---|---|---|---|
| | | | |

(18) Emergency Contact Name: _____ Phone #: (__ __ __) __ __ __ - __ __ __ __
Relationship of Emergency Contact to You: _____

(19) E-mail Address (Optional):
I agree to receive communication by email from Advantra Freedom ❒ Yes ❒ No

(20) **Step 2 PLEASE SELECT A BENEFIT PLAN**
**NOTE:** Not all plans are available in your service area. Check the Summary of Benefits to confirm that the county in which you live is in the service area of the plan you wish to join.

I would like to enroll in: ❒ Freedom 4 ❒ Freedom 5

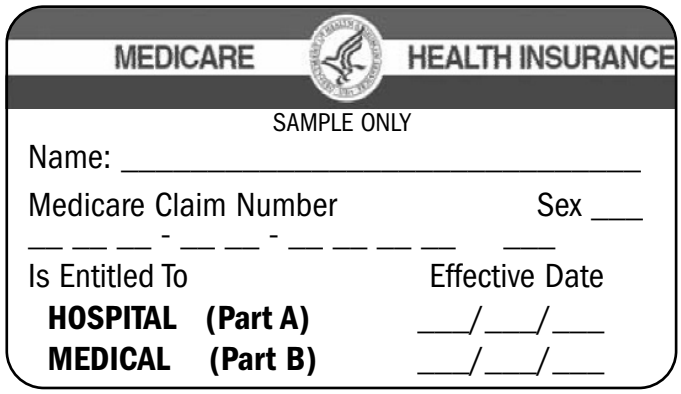
(21) **Step 3 PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION**

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. Make sure you include all letters and numbers.

**– OR –**

- If you have not received your card from Medicare yet, attach a copy of your letter from the Social Security Administration or Railroad Retirement Board.




You must be entitled to Medicare Part A and enrolled in Medicare Part B to join a Medicare Advantage Private Fee-For-Service plan.

If you have any additional questions regarding how to enroll, or how to complete this enrollment application, please call an Advantra Freedom representative at 1-800-711-1607 or TDD for the hearing impaired at 1-866-386-2335, Monday through Friday from 8:00 a.m. to 11:00 p.m., Eastern Standard Time. From November 15, 2006 to March 1, 2007, hours are from 8:00 a.m. to 11:00 p.m., Eastern Standard Time, 7 days a week, including holidays.

**(22) Step 4 PLEASE SELECT ONE PREMIUM PAYMENT OPTION (IF APPLICABLE). Skip this section if your selected plan has NO ($0) premium.**

❑ **Option 1** – You can have the monthly premium automatically deducted from your bank account through an Electronic Funds Transfer. Please complete the enclosed Authorization Agreement for ACH Debit form and return the completed form with a voided check along with your application.

❑ **Option 2** – You can pay the monthly premium directly using a coupon book which will be mailed to you.

❑ **Option 3** – You can have the monthly premium automatically deducted from your Social Security check.

**Generally, you must stay with the option you choose for the rest of the year.**

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if there is any, deducted from your monthly check. (Option 3 ONLY).

**(23) Step 5 PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP MEDICARE COORDINATE YOUR BENEFITS**

**1.** Do you have End Stage Renal Disease (ESRD)? ❒ Yes ❒ No
If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant.

**2.** Do you or your spouse work? ❒ Yes ❒ No

**3.** Do you have other health insurance through you or your spouse's active employment or retirement plan?
❒ Yes ❒ No
If yes, please provide insurance company name _____
Member ID# _____ Group ID# _____

**4.** 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 Advantra Freedom? ❒ 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 |
|---|---|---|
| _____ | _____ | _____ |

**5.** 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 of Institution (number and street):

_____

Telephone Number of Institution: _____

**6.** Are you enrolled in your State Medicaid program? ❒ Yes ❒ No

If "yes," please provide your Medicaid number: _____

**7.** Have you had Medicare prescription drug coverage or other drug coverage that was at least as good as standard Medicare prescription drug coverage since you became eligible to join a Medicare drug plan?
❒ Yes ❒ No
If no, you may have to pay a penalty. Advantra Freedom may ask you to provide evidence that some or all of your previous prescription drug coverage was at least as good as Medicare drug coverage. If you have questions about the late enrollment penalty, call Advantra Freedom Monday through Friday from 8:00 a.m. to 11:00 p.m., Eastern Standard Time. From November 15, 2006 to March 1, 2007, a representative is available from 8:00 a.m. to 11:00 p.m., Eastern Standard Time, 7 days a week, including holidays.

**(24) Step 6** STOP **PLEASE READ THIS IMPORTANT INFORMATION**

**If you currently have health coverage from an employer or union, joining Advantra Freedom could affect your employer or union health benefits.** If you have health coverage from an employer or union, joining Advantra Freedom may change how your current coverage works. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

**Special Notes about your Part D prescription drug coverage:**

- Advantra Freedom provides Medicare medical and Part D prescription drug coverage.
- If you are already enrolled in another plan that provides Medicare Part D prescription drug coverage, enrollment in Advantra Freedom will cause you to be automatically disenrolled from that plan.

**(25) Step 7 PLEASE READ AND SIGN BELOW:**

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

Advantra Freedom is a Medicare Advantage Private Fee-For-Service plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Advantra Freedom or by calling 1-800-MEDICARE. TTY users should call 1-877-486-2048.

Advantra Freedom serves a specific service area. If I move out of the area that Advantra Freedom 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 Advantra® Freedom, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Advantra Freedom when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan 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 plan.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) 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 Advantra Freedom or by Medicare.

| **(25) Your Signature or Authorized Representative (as described above.)** | **(25) Today's Date** |
|---|---|
| | |

**(26) If you are the Authorized Representative, you must provide the following information:**

Name _____ Phone Number (__ __ __) __ __ __ - __ __ __ __

Address _____

Relationship to Enrollee _____

*Advantra® Freedom is a Medicare Advantage Private Fee-for-Service Plan offered through the following Coventry Health Care, Inc. subsidiary who contracts with the Centers for Medicare and Medicaid Services (CMS), a federal agency that administers Medicare: First Health Life & Health Insurance Company.*

*If a person is discussing plan options with you, he or she may be either employed by or contracted with First Health Life & Health Insurance Company, a subsidiary of Coventry Health Care, Inc. This person may be compensated based on your enrollment in the Advantra® Freedom plan.*

*Advantra Freedom and the torch design are registered service marks.*

*This document is available in alternative formats.*

**(27) If you are the Agent/Producer/Broker, you must provide the following information:**

Name (please print) _____

Distribution Partner _____

Agent/Producer ID# _____ Alternate Payee Number _____

Telephone # _____ Application Receipt Date By Agent _____

**Signature of Agent/Producer/Broker** _____

**Advantra Freedom Internal Use Only**

Receipt Date of Application _____ Effective Date of Coverage _____

Election Period: ICEP/IEP: _____OEP: _____AEP: _____SEP (type): _____

Group #_____ Plan Identification # _____

Advantra® Freedom

## Addendum to Enrollment Application — Information to Determine Enrollment Periods

Member Name: _____

Member Medicare Number: _____

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you do not change your prescription drug coverage. However, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements and check the box to the left of the statement(s) and we will contact you for additional information. If none of the statements applies to you or if you are not sure, please contact us to see if you are eligible to enroll. Call an Advantra® Freedom representative at 1-800-711-1607 or TDD for the hearing impaired at 1-866-386-2335, Monday through Friday from 8:00 a.m. to 11:00 p.m., Eastern Standard Time. From November 15 to March 1, 2007, representatives are available from 8:00 a.m. to 11:00 p.m., Eastern Standard Time, 7 days a week, including holidays.

- ❑ I am new to Medicare.
- ❑ I recently moved outside of the service area for my current plan.
- ❑ I have both Medicare and Medicaid or my state helps pay for my Medicare Premiums.
- ❑ I was recently approved for extra help paying for Medicare prescription drug coverage.
- ❑ I just moved "into" a Long Term Care Facility (for example, a nursing home or long term care hospital).
- ❑ I recently "left" a PACE program.
- ❑ I recently involuntarily lost my creditable drug coverage (that is, coverage that is at least as good as Medicare's).
- ❑ I am either losing coverage I had from an employer or leaving employer coverage.