The premium amount contained in this document is pending Federal approval.

Gundersen Lutheran Health Plan, Inc.
1836 South Avenue, Mail Stop: NCA2-01
La Crosse, WI 54601

Medicare Member Services
Local Calls (608) 775-8077 Toll Free 1(800) 394-5566
For people who are deaf, hard of hearing or speech impaired, call TTY 711

Please contact Senior Preferred if you need information in another language or format (Braille).

To Enroll in Gundersen Lutheran Senior Preferred (HMO), Please Provide the Following Information:			
Last Name:	First Name:	MI:	__Mr. __ Mrs. __ Ms.
Date of Birth: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ___ M ___ F	Home Phone Number ( )	Alternate Phone Number ( )
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	State:	Zip:	
County:	Social Security number:		
Mailing Address (only if different from your Permanent Residence Address:			
Address:			
City:	State:	Zip:	

Please Provide Your Medicare Insurance Information

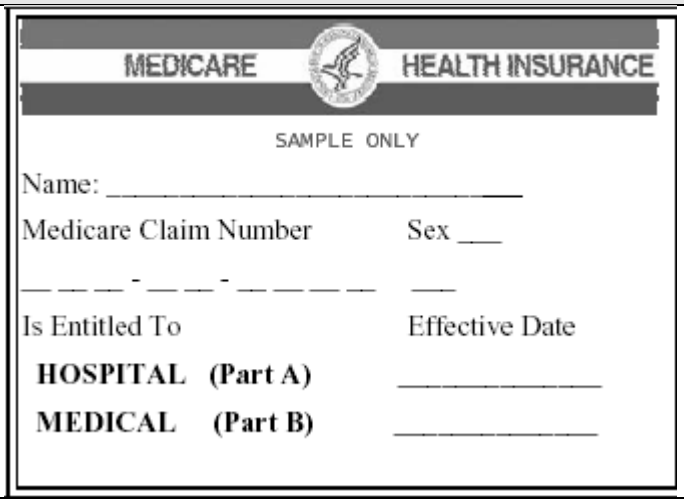
Please take out your Medicare card to complete this section.

- 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.


MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: _____

Medicare Claim Number Sex ___

___ ___ ___ - ___ ___ - ___ ___ ___ ___ ___

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Please read and answer these important questions:	

Spoken Language Preferred for Health Care:	
	English
	Spanish
	Hmong
	Other (please specify)

Preferred Language for Written Materials:	
	English
	Spanish
	Hmong
	Other (please specify)
	Would like information sent in another format (like Braille, audio tape or large print)

Other Language Needs:	
	English
	Spanish
	Hmong
	Other (please specify)

Race:	
	White
	Black
	Asian
	American Indian or Alaska Native
	Native Hawaiian/Other Pacific Islander
	Two or More Races
	Other
	Unknown
	Decline

Ethnicity:	
	Hispanic or Latino
	Not Hispanic or Latino

Plan Options **I am applying for:**		
	Gundersen Lutheran Senior Preferred **Elite**	$100.00 monthly premium plan
	Gundersen Lutheran Senior Preferred **EliteD**	$139.60 monthly premium plan
	Gundersen Lutheran Senior Preferred **Value**	$0.00 monthly premium plan
	Gundersen Lutheran Senior Preferred **ValueD**	$22.60 monthly premium plan

I have selected the following Personal Physician:			
First Choice:	Are you an existing patient?	Yes	No
Second Choice:	Are you an existing patient?	Yes	No

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by coupon book or automatic checking account deduction. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board 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 or Railroad Retirement Board benefit check or be billed directly by Medicare. DO NOT pay the Part D-IRMAA extra amount to Gundersen Lutheran Senior Preferred.

People with limited incomes may quality for extra help to pay for their prescription drug costs. If you qualify, 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 won't have a 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. TYY 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 coupon book.

Please select a premium payment option:

	Automatic checking account deduction (complete Automatic Payment Authorization Form)
	Coupon book – check or money order (no cash accepted)
	Automatic deduction from your monthly Social Security benefit check.
	Automatic deduction from your monthly Railroad Retirement Board benefit check

(The Social Security/Railroad Retirement Board deduction may take two or more months to begin. We will send you a confirmation letter with the effective date this deduction. You are responsible for payment prior to the effective of this automatic deduction. If Social Security/Railroad Retirement Board does not approve your request for automatic deduction, we will send you a coupon book for your monthly premiums.)

The type of election is:	
	Annual Election Period
	Initial Coverage Election Period
	Open Election Period
	Open New Election Period
	Special Enrollment Period (Complete SEP Attestation attached):

Person to notify in an emergency (nearest relative or friend)		
Last Name:	First Name:	MI:
Relationship To Applicant:	Phone Number:	

How would you like to receive your member materials	
	Paper
	Electronic (email address required for this option)
Email Address:	

How did you hear about Senior Preferred?	
	Mailing
	Newspaper
	Radio
	Friend/Relative
	Other (please specify):

Do you have End-Stage Renal Disease (ESRD)?	Yes	No
If you have had a successful kidney transplant and/or don't need regular dialysis anymore, **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.		

Are you a resident in a long-term care facility, such as a nursing home?*	Yes	No
If **YES,** Name of Facility:		
Address:		
City:	State:	Zip:
Phone Number:	Date Entered:	
*Note: This information cannot be used to deny your application for membership in a Gundersen Lutheran Senior Preferred plan.		

Some individuals may have other **drug coverage**, including other private insurance, TRICARE, Federal employee health benefits coverage, VA Benefits, Senior Care or State pharmaceutical assistance programs.		
Will you have other prescription drug coverage in addition to Senior Preferred? **If YES**, what is the name of your insurance? _____	Yes	No
Do you, on your own or through your spouse, have any medical health insurance other than Medicare, such as private insurance or Workers' Compensation? **If YES**, what is the name of your insurance? _____	Yes	No
Will you be keeping this health insurance in addition to Senior Preferred? If no, please indicate term date. _____	Yes	No
Are you enrolled in your State Medicaid program? **If yes, Medicaid Number:** _____	Yes	No

Please Read This Important Information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining Senior Preferred, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

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

Understanding Your Plan Please read these sentences and put your initials next to them:	
1. I understand that Senior Preferred is a Medicare Advantage/Drug Plan and has a contract with the Federal Government and this coverage is in addition to my coverage under Medicare; therefore, I will need to keep my **Medicare Part A and Part B.**	Initials
2. I understand that I can be in only 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.	Initials
3. I understand that it is my responsibility to inform Senior Preferred of any prescription drug coverage that I have or may get in the future.	Initials
4. I understand that if I don't have Medicare prescription drug coverage or if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.	Initials
5. I understand that 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.	Initials
6. I understand that Senior Preferred serves a specific service area. If I move out of the area that Senior Preferred serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I must leave Senior Preferred if I move out of the service area, or if I am away from the service area for more than six months in a row. I understand that if I move permanently out of the service area, Medicare requires the plan to disenroll me.	Initials
7. I understand that I must use network pharmacies except in an emergency (under limited, non-routine circumstances) when I cannot reasonably use Senior Preferred network pharmacies.	Initials
8. I understand that once I am a member of Senior Preferred, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Senior Preferred when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage/Drug plan.	Initials
9. I understand that people with Medicare aren't usually covered under Medicare while out of the country; however, as a member of Senior Preferred you are covered anywhere in the World for urgent and emergent services.	Initials
10. I understand that beginning on the date Senior Preferred coverage begins I must get all my heath care from Senior Preferred, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Senior Preferred and other services contained in my Evidence of Coverage document will be covered. Without authorization, **NEITHER MEDICARE NOR SENIOR PREFERRED WILL PAY FOR THE SERVICES.**	Initials
11. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Senior Preferred, he/she may be paid based on my enrollment in Senior Preferred.	Initials
12. I understand counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program and the Medicare Savings Program.	Initials
13. I understand and acknowledge that I was notified, in advance, that I would be discussing Senior Preferred, with and without prescription drug coverage, with the sales representative, and that during our meeting those were the only insurance products that were discussed.	Initials

Attestation of Eligibility for an Enrollment Period
(complete only if enrolling using SEP election)

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of the annual enrollment 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 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 am making this enrollment request between January 1 and February 14, and I recently ended my enrollment in a Medicare Advantage plan. I left my Medicare Advantage plan on (insert date) _____
	I was enrolled in a Special Needs Plan (SNP) but I lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

Other (please indicate reason eligible to enroll):

Please Read and Sign Below:

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 and 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 Senior Preferred. 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 Senior Preferred or by Medicare.

Signature: _____ Today's Date: _____

If you are the authorized representative, you must sign above and provide the following information:		
Last Name:	First Name:	MI:
Address:		
Relationship To Enrollee:	Phone Number:	

Office Use Only
Name of staff member/agent/broker (if assisted in enrollment):
Additional Comments:

SUBMIT THIS APPLICATION TO:
Gundersen Lutheran Health Plan, Inc.
Senior Preferred
1836 South Avenue, Mail Stop: NCA2-01
La Crosse, WI 54601

Senior Preferred Member Services
Local Calls: (608) 775-8077
Toll Free: 1(800)-394-5566
TTY 711

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS AND INFORMATION

This Authorization must be fully completed and signed as a condition of applying for insurance with Gundersen Lutheran Health Plan, Inc.

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW:

1. Person(s) or group(s) of persons authorized to use or disclose the information: Any licensed physicians, medical practitioners, hospitals, clinics, laboratories, long-term care facilities, medical or medically related facilities, pharmacies, the Department of Health and Human Services (Medicare), reinsurance and insurance companies including Gundersen Lutheran Health Plan.
2. Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information: Gundersen Lutheran Health Plan, the Health Plan's authorized representatives, and the Department of Health and Human Services (Medicare).
3. Description of the information that may be used or disclosed: This authorization includes the disclosure of information related to my health and insurance claims, including but not limited to those containing diagnosis, treatments, prescription drug information, alcohol or drug abuse treatment, mental health (except psychotherapy notes), or information regarding communicable or infectious conditions (but excludes genetic information, HIV test results or AIDS diagnosis.) To facilitate the rapid submission of such information, the undersigned authorizes all such sources to give such records and information to any authorized representative of Gundersen Lutheran Health Plan.
4. The information will be used or disclosed only for the following purpose(s): For the purpose of processing my application, billing, collecting and paying claims, conducting management and financial audits, monitoring and evaluating programs, reviewing health care services, quality improvement, medical management, quality management activities, utilization review, subrogation investigation & recoveries, and complaint resolution.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGEMENT:

- I understand that health information about me provided to Gundersen Lutheran Health Plan is protected by federal and state privacy regulations and that Gundersen Lutheran Health Plan will only use and disclose such information as described in its Notice of Privacy Practices.
- I understand that information that is used or disclosed to an entity that is not covered under the federal privacy laws may be subject to re-disclosure and is no longer protected.
- I understand that I may revoke this authorization in writing at any time, prior to the disclosure of this information. Requests to revoke this authorization can be sent to: Gundersen Lutheran Health Plan, Group Administration, 1836 South Avenue, La Crosse, Wisconsin 54601. I also understand that the revocation of this authorization will not affect the uses and disclosures of my health information for purposes of treatment, payment and business operations. However, failure to sign this authorization may prohibit the release of records, which could result in non-payment of claims.
- Upon request, I understand that I am entitled to receive a copy of this signed authorization.
- I understand that for purposes of processing my application, this authorization shall be valid for 30 months from the date of this application. For all other purposes, this authorization shall be valid during the entire time I am covered under health insurance coverage issued by Gundersen Lutheran Health Plan.
- A copy of this authorization shall be as valid as the original.
- Medical records and information may be disclosed prior to and after the date of this authorization.

SIGNATURE _____ **DATE:** _____

MEDICARE QUESTIONNAIRE

DO YOU HAVE INSURANCE COVERAGE THROUGH AN EMPLOYER PLAN	Yes	No
Are you or your spouse currently working or self-employed?		
Do you have health insurance coverage through that employer?		
Do you have prescription drug coverage through that employer?		

How many employees work for the employer? __1-19 __20-99 __100 or more __don't know

Employer Name: _____
Employer Address: _____
Insurance Company Name: _____
Insurance Company Address: _____
Policy Number: _____
Member ID Number: _____
Rx Group (can be located on your ID card): _____
RX PCN (can be located on your ID card): _____
RX BIN (can be located on your ID card): _____
Date Insurance Began: _____
Date Insurance Termed: _____

DO YOU HAVE PRESCRIPTION DRUG COVERAGE (Other than Senior Preferred)	Yes	No
Do you have any other prescription drug coverage?		
If yes, what is your relationship to the policyholder?		

What type of policy is your other drug coverage? ____TriCare ____MediGap ____VA
____Wisconsin SeniorCare ____State Pharmaceutical Assistance Program _____Other

Insurance Company Name: _____
Insurance Company Address: _____
Policy Number: _____
Member ID Number: _____
Rx Group (can be located on your ID card): _____
RX PCN (can be located on your ID card): _____
RX BIN (can be located on your ID card): _____
Date Insurance Began: _____
Date Insurance Termed: _____

The Centers for Medicare and Medicaid Services require that we survey our members at the time of application and annually thereafter. Please complete the form in its entirety, sign, date, and return in the enclosed envelope.

_____ _____
Signature Date