

Today's Options Enrollment form

Agents selling Today's Options must complete every part of the enrollment form clearly and to the best of their ability. The sample document below highlights each area of the enrollment form and instructs the agent on how to properly complete the enrollment form.

TODAY'S OPTIONS®		
2008 Individual Enrollment Form		
Offered by Pyramid Life		
Section 1: Enrollment Instructions		
Ten easy steps to enroll.		
STEP 1: Please choose the Today's Options plan you wish to enroll in and fill in the premium amount in Section 2 (refer to the Premiums Table located in the Summary of Benefits).		
STEP 2: Please fill out the personal information in Section 3 (Name, Address, Phone Number, etc.).		
STEP 3: Please copy the information requested from your Medicare card in Section 4.		
STEP 4: Check a box in Section 5 to determine your enrollment period.		
STEP 5: Check the box for your preferred premium payment method. To make premium payments via Electronic Funds Transfer (EFT) from your bank account, complete the Bank Withdrawal Pre-Authorization Form (located in Section 6: Your Plan Premium Payment Option on the enrollment application). Please do not submit your premium payment with the Enrollment Form. Your monthly premiums will be directly billed to you if you do not choose Electronic Funds Transfer payment or Social Security check deduction options. A premium statement will be sent to you each month.		
STEP 6: Please answer questions 1–6 in Section 7.		
STEP 7: Please fill out your provider information in Section 8.		
STEP 8: Please read the disclaimer information in Sections 9 and 10.		
STEP 9: Please sign and date the application in Section 10.		
STEP 10: Please make sure your agent signs and dates the application in Section 11.		
If you are a [Health Plan Name] member and wish to make a plan benefit change or change your billing method, STOP HERE. You do not need to complete a new enrollment application. Please call Member Services at 1-800-958-2692 (TTY/TDD 1-800-535-3995) 8 AM–11 PM EST, 7 days a week, or your agent to fill out a Change Notice form.		
Please send the completed Enrollment Form in the enclosed business reply envelope to:		
Regular Mail: Today's Options c/o Patni Computer Systems, Inc. P.O. Box 391889 Cambridge, MA 02139	Overnight: Today's Options c/o Patni Computer Systems, Inc. 625 Mt. Auburn St., Third Floor Cambridge, MA 02138 Email: Tshipment.BPONOida@patni.com Phone: (617) 576-6110	
After we receive your completed Enrollment Form, we will send you an acknowledgement letter and contact the Centers for Medicare & Medicaid Services (CMS) for verification of your eligibility and effective date.		
M0018_TO_AppV2_0807 CMS xxxxx07 H5421 Today's Options PLEASE RETURN TO COMPANY	1	2008 Enrollment Form

Please print legibly, providing information for each section, as shown in this completed sample enrollment form.

AGENTS MAY NOT COLLECT PAYMENT AT THE TIME OF SALE.

TODAY'S OPTIONS®

Completing the Today's Options Enrollment form

Section 2: Plan Selection

Call [1-800-000-0000] to schedule your telephone verification call.

Pyramid Life Telephone Verification Number:

Please check which plan you want to enroll in:

Today's Options \$_____ per month (MA—Does not include drug coverage)

Today's Options \$_____ per month (MA—Does not include drug coverage)

Today's Options \$_____ per month (MA—Does not include drug coverage)

Today's Options \$_____ per month (MA-PD—Includes drug coverage)

Today's Options \$_____ per month (MA-PD—Includes drug coverage)

Today's Options \$_____ per month (MA-PD—Includes drug coverage)

Section 3: Personal Information

WRITE NAME EXACTLY AS SHOWN ON MEDICARE CARD

LAST name: FIRST name: M.I.

Suffix/Title: Birth Date: Social Security Number: Sex: M F

(M M / D D / Y Y Y Y) (###-##-####)

Please affix your permanent address label HERE, if available:

Home Phone Number:

Cell Phone Number:

Permanent Residence Street Address Line 1:

Permanent Residence Street Address Line 2: (Apt/Ste/Unit) County:

City: State: ZIP Code:

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

Street Address or P.O. Box Number: City: State:

ZIP Code: E-mail Address:

Emergency Contact:

Phone Number: Cell Phone Number: Relationship to You:

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Verification Number

Write the number in designated field.

Plan & Premium

Make sure you check the correct product and write in the correct premium amount.

The name at the top of the enrollment form must match the name on the Medicare Card.

County

Don't forget this box. It is crucial for assigning the enrollee monthly payments.

Include Personal Medicare Number

Include the Medicare Claim number (also called Health Insurance Claim (HIC) number) exactly as it appears on the enrollee's red, white and blue Medicare card, plus any letters that appear before or after the number. Please check to make sure the number is legible.

Enrollment Period

Review this section with the enrollee and check all that apply.

Section 4: 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 the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

An incorrect or incomplete Medicare claim number may cause a delay or denial of coverage.

Section 5: Information to Determine Enrollment Periods

You may enroll in a Medicare Advantage plan during the Annual Enrollment Period (November 15–December 31). In addition, you can join a Medicare Advantage plan during the Open Enrollment Period (January 1–March 31), as long as you do not change your prescription drug status.

Please read the following statements and check the box to the left of the statement(s) that applies. The Enrollment Department may contact you if additional information is needed.

I am new to Medicare.

I recently moved outside the service area for my current plan.

I receive extra help paying for Medicare prescription drug coverage.

I recently moved "out" of a long-term care facility (for example, a nursing home).

I recently "left" a PACE program.

I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's).

I am either losing coverage I had from an employer or leaving employer coverage.

I belong to a pharmacy assistance program provided by my state.

I recently returned to the U.S. after living permanently outside of the U.S.

I am no longer eligible for extra help paying for my Medicare prescription drugs.

I am enrolled in the Original Medicare Plan.

Other (please explain) _____

If none of these statements apply to you or if you are not sure, contact Member Services at [1-800-000-0000 (TTY 1-800-000-0000) 8 AM–11 PM EST, 7 days a week,] to see if you are eligible to enroll.

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Stop and read these sections aloud to the enrollee and/or allow the enrollee to read to be sure the enrollee fully understands.

Enrollee signature and date

The Medicare beneficiary must sign here. If there is an individual legally authorized to represent the Medicare beneficiary, they should complete Section 10.

Note: the agent is not the authorized representative.

STOP Section 9: Please Read This Important Information STOP

If you currently have health coverage from an employer or union, joining Today's Options, could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Today's Options 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.

Section 10: Please Read and Sign Below:

By completing this enrollment application, I agree to the following:
 Today's Options is a Medicare Advantage plan and I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform Today's Options of any prescription drug coverage that I have or may get in the future. I understand that if I do not 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 an entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to [Health Plan Name] or by calling 1-800-MEDICARE; TTY 1-877-486-2048, 24 hours a day, 7 days a week.

Today's Options serves a specific service area. If I move out of the area that [Health Plan Name] 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 Today's Options, I have a right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from [Health Plan Name] when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the county except for limited coverage in Canada and Mexico.

The person who is discussing plan options with me is either employed by or contracted with Pyramid Life. This person may be compensated based on my enrollment in the plan.

Authorization to release 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. I also acknowledge that [Health Plan Name] 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 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 Today's Options or by Medicare.

Contracting Statement:
 I certify that I have enrolled in Today's Options, a Medicare Advantage Private Fee-for-Service plan. A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare Supplement plan. Your doctor or hospital must agree to accept the plan's terms and conditions prior to providing healthcare services to you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may not provide healthcare services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at www.todaysoptions.com/providers.aspx.

Your Signature:

Your Name: (please print) _____ Today's Date: ____/____/____
 [Grid for name and date]

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Section 10: Please Read and Sign Below (continued):

If you are legally authorized to represent the enrollee, you must provide the following information (not for agent use): (Power of Attorney (POA) documentation needs to be submitted with the application)

Name: _____
 Address: _____
 City: _____ State: ____ Zip: _____
 Phone Number: (____) _____ - _____ Cell Phone Number: (____) _____ - _____
 Relationship to Enrollee: Child Friend Spouse Other _____
 Signature: _____ Today's Date: ____/____/____

Section 11: Agent Use Only

Agent Name (please print): _____ Today's Date: ____/____/____
 Agent ID #: _____ Agent Signature: _____

Election Period: AEP ICEP SEP OEP
 If SEP, choose one: New to Medicare, not BS Institutional Relocation Loss of Employer Coverage LIS Other: _____

Internal Use Only

APPLICATION RECEIVED AT THE HEALTH PLAN Proposed Effective Date: ____/____/____

APPLICATION RECEIPT TRACKING

Initial Receipt Date at Field Office	Medicare Services Inventory Control Receipt	Medicare Services Deemed Complete
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Group Code: _____

Provider # _____ Cycle # _____ FBP # _____

The Today's Options benefit packages, plan premiums, copayments/coinsurance and service areas are all subject to change annually at Pyramid Life contract renewal time with the Centers for Medicare and Medicaid Services January 1. Availability of coverage beyond the end of the current year is not guaranteed. Today's Options is offered by Pyramid Life, an insurance company with a Medicare Advantage contract to offer a Private Fee-for-Service plan. Pyramid Life and its agents are not connected in any way with the federal or state government or Medicare.

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Authorized Representative

If there is an individual legally authorized to represent the enrollee, they should complete section 10. Note: the agent is not the authorized representative.

Agent name and ID number

Print your name and agent number clearly. Make certain both are easy to read.

Election Periods

Choose appropriately: AEP (Annual Election Period); ICEP (Initial Coverage Election Period); SEP (Special Election Period); OEP (Open Election Period).