To Enroll in FRIDAY HEALTH PLANS (COST),
Please Provide the Following Information:

Please check which plan you want to enroll in:

_____ Friday Health Plans Silver Plan (Cost) Premium: $30 per month*

_____ Friday Health Plans Gold Plan (Cost) Premium: $50 per month*

_____ Friday Health Plans Platinum Plan (Cost) Premium: $80 per month*

*You must continue to pay your Part B premiums

Please indicate your requested enrollment effective date: _____

LAST Name: FIRST Name: Middle Initial		☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M/ D D / Y Y Y Y)	Gender: ☐ M ☐ F	Phone Number: ( )
Permanent Residence Street Address:		
City:	State: ZIP Code:	

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

Street Address: City: State: ZIP Code:

Emergency contact: _____
Phone Number:_____
Relationship to You _____

Please Provide Your Medicare Insurance Information

Please take out your *red, white and blue* Medicare *card* to complete this section.

- *Fill out this information as it appears on your* Medicare card

-OR-

- Attach a copy of your Medicare card or your letter from the Social Security Administration *or the* Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

Is entitled to: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Part B to join a Medicare cost plan.

Your Plan Premium Payment Options

You can pay your monthly plan premium by mail, Electronic Funds Transfer (EFT), each month. You can also choose to pay your premium by automatic deduction from your Social Security Check each month.

If you don't select a payment option, you will receive a coupon book.

Please select a premium payment option:

☐ Receive a coupon book annually
☐ 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: _ _ _ _ _ _ _ _ _ Bank account number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Account type: ☐ Checking ☐ Saving
Automatic deduction from your monthly *Social Security or Railroad Retirement Board (*RRB) benefit check.
I get monthly benefits from: ☐ *Social Security* ☐ *RRB*
(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 not include all premiums due from your enrollment effective date up to the point withholding begins. We will send you a coupon book for those months before deduction from your Social Security/RRB check starts. If Social Security *or* RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please read and answer these important questions:

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
Do you have health coverage through you or your spouse's current or former employer? ☐ Yes ☐ No
If "yes" please provide the following information:
Employer Name; _____ Employer Address: _____
Policy Holder Name: _____ Policy Number: _____

3. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No
If yes, please provide your Medicaid number: _____

Please choose the name of a Primary Care Physician (PCP), clinic or health center (if required):
_____

Please check one of the boxes below if you would prefer us to send you information in a language other than English:
_____ Spanish
_____ Other: _____

Please Read and Sign Below:

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

Friday Health Plans (Cost) is a Medicare health plan and I will need to keep my Medicare Part B. I can be in only one Medicare Health 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. I know I may disenroll from this plan at any time by sending a written request to Friday Health Plans or by calling 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

I understand that beginning on the date Friday Health Plans (Cost) coverage starts, in order for Friday Health Plans (Cost) to fully cover my medical services (except for emergency or ugently-needed services), all of my health care must be provided or arranged by Friday Health Plans (Cost). If I obtain services not provided or arranged by the plan, I will be responsible for all Medicare deductibles and coinsurance, as well as any additional charges as prescribed by the Medicare program. I may also be liable for charges not covered by Medicare.

Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico. Services authorized by Friday Health Plans (Cost) and other services contained in my Friday Health Plans (Cost) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered.

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 *my* behalf under State law 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 by Friday Health Plans (Cost) or by Medicare.

Your Signature:	**Today's Date:**

If you are the authorized representative, you must provide the following information:
Name: _____
Address: _____
Phone Number: (___) ____-_____
Relationship to Enrollee: _____

Office Use Only:
Name of staff member (if assisted in enrollment): _____
Plan ID#: _____

[Enrollment Period when applicable] IEP: _____ AEP: _____ SEP (type): _____

Friday Health Plans is a Cost plan with a Medicare contract. Enrollment in Friday Health Plans' Medicare Cost Plan depends on contract renewal.
You must continue to pay your Medicare Part B premium.
The provider network may change at any time. You will receive notice when necessary.
This information is available for free in other languages. Please call our customer service number at 1-800-475-8466, TTY 1-800-659-2656, from 8:00 am to 8:00 pm, 7 days a week, Oct 1 – Feb 14 and 8:00 am to 8:00 pm, Monday through Friday, Feb 15 – Sep 30.
Esta información está disponible gratis en otros idiomas. Por favor llame a nuestro número de servicio al ciente al 1-800-475-8466, TTY 1-800-659-2656 de 8:00 am a 8:00 pm, los 7 días de la semana, Oct 1 – Feb 14, y 8:00 am a 8:00 pm, de Lunes a Viernes, Feb 15 – Sep 30.