

# C AND O EMPLOYEES' HOSPITAL ASSOCIATION

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CLIFTON FORGE, VIRGINIA 24422-1166  
TELEPHONE (540) 862-5728/5729 (800) 679-9135 FAX (540) 862-3552/4958  
1897-2017 MORE THAN 100 YEARS OF EXCELLENCE

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## C and O Employees' Hospital Association Medicare Supplement & Part D Enrollment Form

**To Enroll in the C and O Employees' Hospital Association (COEHA), Please Provide the Following Information:**

**PLEASE TYPE OR PRINT. Please check the plan in which you want to enroll:**

Plan Seven which includes hospital, medical and Medicare Part D Prescription Drug coverage. \$300.00 per month

Plan Ten which is hospital and medical coverage only. \$210.00 per month


LAST name:		FIRST name:	Middle Initial:
Birth Date: ( ___ / ___ / ___ ) (MM/DD/YYYY)	Sex: M or F (circle)	Social Security Number _____	Home Phone Number: ( ) _____
Permanent Residence Street Address (P.O. Box is not allowed): _____			
City:	State:	ZIP Code:	
Mailing Address (only if different from your Permanent Residence Address): _____ Street Address: City: State: ZIP Code: _____			
Emergency contact person: _____			
Phone Number: ( ) _____ Relationship to You: _____			
E-mail Address: _____			

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 both Medicare Part A and Part B to join our Supplemental Medicare plan.

	
MEDICARE	HEALTH INSURANCE
SAMPLE ONLY	
Name: _____	
Medicare Claim Number _____	Sex _____
_____ - _____ - _____	
Is Entitled To _____	Effective Date _____
<b>HOSPITAL (Part A)</b> _____	
<b>MEDICAL (Part B)</b> _____	

Date you wish your Medicare Supplemental coverage to begin: \_\_\_ / \_\_\_ / \_\_\_

Marital Status: \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widowed .

Name of the railroad (or other company) from which you retired if other than CSX \_\_\_\_\_

If you are the spouse, parent or parent-in-law of a COEHA member, please give member's name and Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**COEHA MEDICARE HEALTH CARE PREPAYMENT PLAN (HCPP):**

As a member of our Medicare Supplemental Plan, you are automatically enrolled in the COEHA Medicare Health Care Prepayment Plan unless you have End-Stage Renal Disease. As an HCPP, we are contracted with the federal government as an HCPP Carrier for the HCPP Medicare members and will process the Medicare Part B claims from COEHA network participating physicians. COEHA shall pay medically necessary Medicare Part B (medical) HCPP Health Care services in one combined payment to include primary and secondary payment. We will be paid a fee from the federal government for processing your physician's claims for Medicare benefits.

**Advantages for you:**

- Handling of your Part B Medicare services will be expedited since claims will be filed and processed at one location: COEHA
- You will never receive a bill from your physician for covered Medicare services
- You will never have to file a physician's claim with COEHA
- You will never have to call or write Medicare in regard to your physician's services

**Advantages for your COEHA network physician:**

- COEHA physicians will receive their monies much faster
- COEHA physicians will only have to file one claim to one location: COEHA
- COEHA physicians never have to send you a bill – they reduce their costs
- COEHA physicians will never have to call Medicare regarding your benefits – they reduce their costs

**ADVANCE DIRECTIVE INFORMATION:**

This will acknowledge that I received from COEHA, at the time of enrollment, information concerning an advance directive. This information explains my right to make decisions concerning my medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate, at my option, an advance directive concerning my care. I further understand that a form of advance directive is available to me from COEHA upon request if I do not have one.

**Paying Your Plan Premium**

**You can pay your plan premium by mail each month, quarterly, semi-annually or annually. Your monthly premium can also be deducted thru “Electronic Funds Transfer (EFT)”. This deduction is made on the 5<sup>th</sup> of each month or first business day thereafter.**

**If you owe any Late Enrollment Penalty, this penalty will need to be mailed to us separately from your plan premium. This Penalty is billed twice annually or we can bill you monthly at your request.**

*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 the C and O Employees’ Hospital Association.*

People with limited incomes may qualify 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. TTY users should call 1-800-325-0778. You can also apply for extra help online at [www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.gov/prescriptionhelp).

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay part of your plan premium. Effective January 1, 2018, we have contracted with Navitus MedicareRx to administer your Medicare Part D Prescription Drug Plan. Since this is an enhanced Part D Plan, you will be responsible for a portion of your prescription drug plan premium.

If you don’t select a payment option, you will receive a bill each month.

**Please select a premium payment option: (check only one)**

A.  I have enclosed the first dues payment and wish to pay monthly, quarterly, semi-annually or annually. Payment is due on the 5<sup>th</sup> of the month. If payment has not been received by the 14<sup>th</sup> of the month, I will receive a bill.

B.  I do hereby authorize The C and O Employees Hospital Association to have my dues premium withdrawn from my checking account. My current rate is \$ \_\_\_\_\_. I understand that this premium may increase and I may cancel at any time. I understand this premium will be deducted on the fifth of each month. Enclosed is a voided blank check from my checking account.

Account holder name: \_\_\_\_\_ Account Type:  Checking  Savings  
Bank routing number: \_\_\_\_\_ Bank account number \_\_\_\_\_

Please Answer the following Questions:

1. Some individuals may have other supplemental and/or drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Are you or your spouse currently employed?  Yes  No

Do you currently have prescription drug coverage?  Yes  No

If yes, please answer the following questions: Is your current prescription drug plan a Medicare Part D Plan?  
Yes \_\_\_\_\_ No \_\_\_\_\_

If your current prescription drug plan is not a Medicare Part D Plan, does it cover as much as a Medicare Part D Plan? Do you have a letter stating your coverage is creditable? Yes \_\_\_\_\_ No \_\_\_\_\_

Please provide us with a copy of the letter.

Will you have other Medicare supplemental coverage in addition to COEHA?  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: \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

2. 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): \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_ Date of Admission: \_\_\_\_\_

3. Do you have End Stage Renal Disease (ESRD)? ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive.  Yes  No

4. Do you have Diabetes?  Yes  No

5. Do you receive Medicaid benefits?  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 COEHA, 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 COEHA could affect your employer or union health benefits. You could lose your employer or union health coverage if you join COEHA. 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 information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read and sign below:

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

**Navitus MedicareRx is a Medicare drug plan and has a contract with the federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A and Part B coverage. It is my responsibility to inform COEHA of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in COEHA will end that enrollment.**

**Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.**

**I understand that I must use Navitus MedicareRx network pharmacies except in an emergency when I cannot reasonably use their network pharmacies. Once I am a member of COEHA, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Navitus MedicareRx when I get it to know which rules I must follow to get coverage.**

**I understand that 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.**

**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.**

**Release of Information:**

**By joining this Medicare Supplemental and prescription drug plan, I acknowledge that COEHA will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Navitus MedicareRx will release my information, including my prescription drug event date, 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 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 Medicare.**

**Signature: \_\_\_\_\_ Today's Date \_\_\_\_\_.**

**If you are the authorized representative, you must sign above and provide the following information:  
Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone No. \_\_\_\_\_ Relationship \_\_\_\_\_**

All organizations that provide Medicare Managed Care Plans, and Health Care Prepayment Plans, like COEHA, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

**Discrimination is against the law.** COEHA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. COEHA does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

COEHA:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Ms. Michelle Hoke, the Civil Rights Coordinator.

If you believe that COEHA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Michelle Hoke  
C and O Employees' Hospital Association  
511 Main Street, 2nd Floor  
Clifton Forge, Virginia 24422-1166  
(800) 679-9135 (toll free)  
(540) 862-3552 (fax)  
[michellehoke@coeha.com](mailto:michellehoke@coeha.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ms. Michelle Hoke, Civil Rights Coordinator, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-679-9135.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-679-9135 번으로 전화해 주십시오.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-679-9135.
Chinese	注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電1-800-679-9135.
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-679-9135
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-679-9135.
Persian (Farsi)	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان 1-800-679-9135 برای شما فراهم می باشد. با تماس بگیرید.
Amharic	ማሳሰቢያ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም አርዳታ ድርጅቶች በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚኒተላው ቁጥር 1-800-679-9135.
Urdu	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-800-679-9135
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-679-9135.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-679-9135.
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-679-9135 पर कॉल करें।
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-679-9135.
Bengali	লক্ষ্য করুন: যদি আপনার বিদেশী কথা বলতে পেরেন, তখনোনিধিরচক্র ভাষাসহায়তা পরাম্বিরোউপলবধ আছে ফোন করুন ১-১-৮০০-৬৭৯-৯১৩৫
Kru (Bassa)	Dè dè nà kè dyédé gbo: Ǿ jǔ kè m̄ [Bàsóò-wùdù-po-nyò] jǔ ní, ní, à wuǰu kà kò dǒ po-poò bém m̄ gbo kpáa. Đá 1-800-679-9135.
Ibo	Ige ntí: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-800-679-9135.
Yoruba	AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-800-679-9135.

If you have any questions, please do not hesitate to give us a call at 1-800-679-9135 or locally at 862-5728. Thank you.