

Thank you for your interest in applying for the SoundPath Medicare Advantage plan.

If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date.

Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15th to December 7th 2011. This will give you a January 1st 2012 effective date for your new plan. Applications must be signed and dated on, or between October 15th and December 7th 2011. If they are signed prior to October 15th they will be returned to you with a new application. If they are received after December 7th, you will not be able to change plans until the next AEP for January 2013.

This application needs to be reviewed and signed by an Agent before it can be submitted to SoundPath. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: dann@lowinsure.com
- Mail: CDA Insurance LLC
2160 W 11th Ave
Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf)
Download Asent/Alpine Summary of Benefits (.pdf)
Download Other Summaries of Benefits (.pdf)

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.



Soundpath HEALTH

Enrollment Check List

Avoiding these common mistakes will help us reduce any unnecessary delay of your application and get you enrolled quickly:

- ✓ Did you provide your Medicare part A & B effective dates and number?
- ✓ Did you choose a Primary Care Provider (PCP)?
- ✓ Did you include information about any other health insurance coverage you have (if applicable)?
- ✓ Did you include a completed payment options form?
- ✓ Did you sign your application?
- ✓ Did you ask your broker or sales agent whether you need to act to cancel your other coverage?

PO Box 4537
Federal Way, WA 98063

Phone 1-866-789-7747
Fax 253-779-8829
(TTY/TDD) 1-866-264-4141

SOUNDPATH HEALTH ENROLLMENT FORM

Office Use Only

Name of staff member/agent/broker (if assisted in enrollment) Dann Loewenthal - CDA Insurance		Broker ID#	Application Date	
Member ID#	Effective date of coverage	ICEP/IEP	AEP	SEP (type)

Instructions: We cannot accept this application until you complete all of the following information.
You must have Medicare Part A and be enrolled in Medicare Part B to join a Medicare Advantage Plan.

Personal Information

Please Check <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.	Last Name as it appears on Medicare card	First Name	MI	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth (mm/dd/yyyy)	Home Phone (xxx-xxx-xxxx)	E-mail		
Permanent Residence Address (P.O. Box not allowed)	City	County	State	Zip
Mailing Address (if different from street address)	City	County	State	Zip

How did you hear about Soundpath Health? _____

Medicare Insurance Information

MEDICARE		HEALTH INSURANCE
SAMPLE ONLY		
Name: _____		
Medicare Claim Number	Sex _____	

Is Entitled To:		
<input type="checkbox"/> Hospital Insurance (Part A)	_____	
<input type="checkbox"/> Medical Insurance (Part B)	_____	

Please take out your Medicare card to complete this section.

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

OR

Medicare Information: Fill in these blanks so they match your red, white and blue Medicare card. **You must have Medicare Part A and be enrolled in Medicare Part B to join a Medicare Advantage plan.**

Your Medicare Advantage Plan Choice

1. Please check the plan you want to enroll in:

Plans WITH Prescription Drug Coverage

- Sound+Rx (HMO): \$0 per month
- Charter+Rx (HMO): \$94 per month
- Apex+Rx (HMO): \$169 per month

Plans with NO Prescription Drug Coverage

- Ascent (HMO): \$0 per month
- Alpine (HMO): \$49 per month

Please Choose Your Primary Care Provider (can't be a specialist):	Is this your current primary care provider? Y / N
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Optional Supplemental Coverage

2. Please check the Optional Supplemental Coverage(s) you want to enroll in:

- Alternative: \$9 per month
- Dental: \$63 per month

Please Read and Answer These Important Questions:

- 1. Do you have End Stage Renal Disease (ESRD)?** No Yes If you answered "yes" to this question and you don't need regular dialysis anymore, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant.
- Some individuals may have other medical or prescription drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State pharmaceutical assistance programs. Will you have other coverage in addition to Soundpath Health?
 No Yes If "yes," please list your other coverage and your identification (ID) number(s):
Coverage Name: _____ Coverage ID #: _____ Coverage Group #: _____
Medical _____
Prescription Drug _____
- 3. Are you a resident in a long-term care facility, such as a nursing home?** No Yes
If "yes", please provide the following information:
Name of Institution: _____
Address (number and street) of Institution: _____
Phone Number of Institution: _____
- 4. Are you enrolled in your State Medicaid program?** No Yes If "yes", please provide a copy of your ID Card. Medicaid number: _____
- 5. Do you or your spouse work?** No Yes If "yes", do you have other coverage? No Yes
If "yes", please list your other coverage above in question #2.

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

- Language: _____ Format: (like Braille, audio tape or large print)

Please contact Soundpath Health at 1-866-789-7747 (TTY users should call 1-866-264-4141) if you need information in another format or language than what is listed above. Our office hours are Monday through Friday, 8 am to 8 pm, and Saturday and Sunday, 8 am to 8 pm between October 15 and February 14.



Please Read the Important Information on Back BEFORE signing

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.** 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 Soundpath Health or by Medicare.

Your Signature: _____ **Date:** _____

If you are the authorized representative, you must sign above and provide the following information:

Name: _____ **Relationship to Enrollee:** _____

Address: _____ **Phone:** _____

Please Read This Important Information!

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

Please Read Before Signing

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

Soundpath Health is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. **I can only be in 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.** It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't 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 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, 2011), or under certain special circumstances.

Soundpath Health serves a specific service area. If I move out of the area that Soundpath Health 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 Soundpath Health, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Soundpath Health when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Soundpath Health coverage begins, I must get all of my health care from Soundpath Health physicians except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Soundpath Health and other services contained in my Soundpath Health Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR SOUNDPATH HEALTH WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Soundpath Health he/she may be paid based on my enrollment in Soundpath Health.

I understand that by providing my contact information, including phone number and email address, I hereby give Soundpath Health permission to contact me via e-mail and phone.

Release of Information:

By joining this Medicare health plan, I acknowledge that Soundpath Health will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Soundpath Health 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.

