USC Senior Care **Application for Enrollment**

A Supplemental Plan to Medicare for Retirees of the University of Southern California

Please read the following information carefully before you complete each of the sections contained within this Application for Enrollment. If you and your spouse/registered domestic partner are applying, please complete one form per person. **Please type or print.** Coverage does not become effective until this application has been approved by USC Health Plans. If you have any questions about completing this form, please call our office at **(213) 740-0035.**

Section 1 — Please complete the information in this section.

Last Name	First Name	M.I.	Social Security Number	Date of Birth

Residence Address	City	State	Zip

Telephone Number	Alternate Number	Date of Retirement:	Date you want to be Effective:
( )	( )	_____	_____

Status: ☐ Retired Faculty ☐ Retired Staff ☐ Board of Trustee

☐ Spouse/Registered domestic partner of Retiree _____ Name of USC Employee/Retiree _____ SS# of USC Employee/Retiree

Section 2 — Please provide your Medicare information.

Please complete the sample Medicare card to the right from the information on YOUR red, white and blue Medicare card. Copy each line exactly as it appears. The information is also provided in your Letter of Verification from the Social Security Administration. If you have not received your Medicare card or your Letter of Verification, contact your nearest Social Security office for this information.

You need to submit a copy of your Medicare ID card with your application.

Medicare Health Insurance
SOCIAL SECURITY

Name of Beneficiary: (YOUR NAME)

_____

Medicare ID Number: _____

Gender _____

Is Entitled to:	Effective Date
Hospital insurance (Part A)	_____
Medical insurance (Part B)	_____

Section 3 — Please read questions 1 through 4 and answer YES or NO.

1. Do you or your spouse/registered domestic partner currently work, or plan to work, for an employer who provides employee group health coverage? ☐ YES ☐ NO
2. Do you have health coverage through your spouse's/ registered domestic partner's employer or any other source?..... ☐ YES ☐ NO
3. Are you currently enrolled in another Medicare Supplemental Plan, Medicare+Choice Plan or maintain other health insurance coverage? ..... ☐ YES ☐ NO
   a) If yes, with which company?_____
4. Are you receiving benefits through Medi-Cal/Medicaid (state subsidized medical plan)? ..... ☐ YES ☐ NO

Section 4 — Please complete the following information pertaining to premium payment.

How do you wish to pay your monthly premiums to USC Senior Care?

A. ☐ Monthly Automatic Checking Withdrawal (please complete **Form A**).

B. ☐ Monthly Visa/Master/Discover Charge (please complete **Form B**).

Section 5 — Please read the Conditions of Election and Authorization to Exchange Information on the back of this form.

I have read, understand, and agree to the statements on the reverse side of this Enrollment Application Form. I hereby apply for USC Senior Care coverage. I alone am responsible for the accuracy and completeness of this Application. I understand that I will not be eligible for coverage if any material information, is intentionally false, and that coverage may be revoked based on such finding in accordance with applicable law.

SIGNATURE OF APPLICANT Date

REPRESENTATIVE SIGNATURE** Date

**If this is being submitted by a guardian, conservator or person with power of attorney, please attach to the Enrollment Application Form the legal documents establishing guardianship, conservatorship or the power of attorney. This verification must be submitted within 30 days or this Application will be denied.

Did you remember to:

☐1. Sign your application

☐2. Include a copy of your Medicare ID card ☐3. Include a signed copy of your Premium Payment form

FOR OFFICE USE ONLY

Plan Start Date:_____ ID Number: _____ Completed By:_____

USC Senior Care - *A Supplemental Plan to Medicare for Retirees of the University of Southern California*
USC Health Plans
851 Downey Way, HSH-101B
Los Angeles, CA 90089-1057
(213) 740-0035 or **healthplans@usc.edu**

Conditions of Election

If you are electing USC Senior Care coverage, be certain that you fully understand the benefits, limitations and conditions, which are described in this application as well as in the Summary Plan Description for USC Senior Care ("Summary Plan Description").

Please read the following statements before you sign the form.

a) I am actively enrolled on both Medicare Part A and Part B. If I fail to maintain my enrollment in both Medicare Part A and Part B, I understand that my enrollment in USC Senior Care will be cancelled.

b) I understand that during my enrollment with USC Senior Care, I cannot be enrolled in another Medicare Supplemental Coverage Plan, Medicare+Choice, or any other health insurance plan (e.g. as an employee, former employee, retiree or as an individual) other than Medicare Part A and Part B. If I do so, my enrollment with USC Senior Care will be cancelled.

c) I have read and understand the benefits, limitations and exclusions of the USC Senior Care coverage contained in the Summary Plan Description.

d) I understand and agree to be bound by the applicable USC Senior Care Summary Plan Description. USC Senior Care shall have access to and use my medical records for the purpose of utilization review, quality assurance, claims processing and/or other purposes related to the performance of this Agreement in accordance with applicable law.

e) I understand that I will be notified by mail (at the address of record) of the effective date of my USC Senior Care coverage. The effective date of my Plan coverage will be the first day of the month following approval of my application by USC Health Plans, provided I am enrolled in Medicare Part A and Part B and I am not enrolled in another Medicare Supplemental Coverage Plan, Medicare+Choice, or any other health insurance plan. Otherwise, the effective date of my coverage will begin the first day of the following month in which all above conditions have been met.

f) I understand that I should not disenroll from any other health insurance coverage that I may have until USC Health Plans has notified me in writing of my acceptance under USC Senior Care and the effective date of my coverage.

g) Coverage under USC Senior Care does not apply to services provided before the effective date of that coverage or to services provided after such coverage has ceased.

h) I understand that I am entitled to all benefits under USC Senior Care as long as my premiums owed to USC Health Plans are kept current. **PREMIUMS ARE DUE ON OR BEFORE THE FIRST DAY OF EACH MONTH**. USC Health Plans reserves the right to immediately terminate my participation under USC Senior Care should any premiums not be received by the first day of the month.

i) I agree that USC Senior Care is not liable to pay any bills in the event I am considered not eligible at the time services are rendered or I have received medical services which are not covered by Medicare.

j) I agree that it is my responsibility to notify USC Health Plans of any changes in my residence/billing address or health insurance coverage, including any change in my eligibility for Medicare coverage.

k) I understand that I may request termination of USC Senior Care at any time by submitting a written request for disenrollment to USC Health Plans **at least (30) days prior to the month in which termination is to be effective.**

l) I understand that USC Health Plans reserves the absolute right to amend or terminate USC Senior Care (the "Plan"), or to terminate any benefit under USC Senior Care for any reason whatsoever. USC Health Plans has the discretionary authority to determine eligibility for benefits, to interpret the Plan, and to decide claims under the terms of the Plan. USC Health Plans may delegate such authority to a claims administrator. Subject to applicable law, any interpretation of the Plan and any decisions on any matter within the discretion of USC Health Plans made by USC Health Plans in good faith shall be binding on all persons.

Authorization to Exchange Information
By submitting this application, I hereby authorize the Health Care Financing Administration (HCFA) to furnish information to USC Health Plans, regarding claims information as well as confirming my Part A (hospital) and Part B (medical) Medicare enrollment and, if my enrollment is terminated, the effective date of termination.