The MA-PD plans offered through EGID serve a specific service area. If I move out of that service area, I need to notify EGID and the plan so I can disenroll and find a new plan in my new area. Once I am a member of an MA-PD plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the member handbook or Evidence of Coverage document from the MA-PD plan when I get it so I know which rules I must follow to get coverage through my MA-PD 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 my MA-PD plan coverage begins, I must get all of my health care from that plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by the MA-PD plan and other services contained in my MA-PD Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MY MA-PD PLAN WILL PAY FOR THE SERVICES.**

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. I also acknowledge that this MA-PD plan 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 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 from Medicare.

Member Signature: _____ Date: _____

Dependent Signature: _____ Date: _____
(Required only if dependent is enrolling in an MA-PD plan.)

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

Name: _____

Address: _____

Phone Number: (___) _____

Relationship to Enrollee: _____

You must return this form to EGID at the address or fax number listed below.

For more information regarding this application, contact EGID:

Office of Management and Enterprise Services
Employees Group Insurance Division
3545 N.W. 58th Street, Ste. 110, Oklahoma City, OK 73112
1-405-717-8780 or toll free 1-800-752-9475 or TDD 1-405-949-2281 or toll free TDD 1-866-447-0436
Fax 1-405-717-8939