SeniorCare (Cost)
SCOTT&WHITE HEALTH PLAN
Now part of Baylor Scott & White Health

CHANGE FORM

STOP! You do not need to complete this form if you want to remain on your current plan(s).	
ID Number:	Medicare Claim Number (from your Medicare card):
Last Name / First Name / Middle Initial:	
Home Phone Number: ( )	Date of Birth:
Mailing Address: (City) (State) (Zip Code)	
(optional) E-mail: _____	

Check only the box(es) of the plan(s) you want to change.

MEDICAL PLAN OPTIONS: I want to **change** my SeniorCare medical plan to:

☐ Select ☐ Preferred ☐ VIP ☐ Premium

RX PLAN OPTIONS: I want to **add or change** my SeniorCare Rx prescription drug plan to:

☐ Value Rx (available only to members enrolled in the Select Medical plan)
☐ Basic Rx (available only to members enrolled in Preferred, VIP, or Premium medical plans)
☐ Enhanced Rx (available only to members enrolled Preferred, VIP, or Premium medical plans)
☐ Cancel my SeniorCare Rx plan.

DENTAL:

☐ I want to **add** MetLife dental coverage for an additional monthly premium. I understand I must use MetLife dental providers.
☐ I want to **cancel** my dental coverage.

By completing this "Change" form, I agree to the following:

SeniorCare (Cost) is a Medicare health plan and I will need to keep my Medicare Part B. I can only be in 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 SeniorCare or by calling 1-800-Medicare or www.medicare.gov, 24 hours a day/7 days a week. TTY users should call 1-877-486-2048.

I understand that beginning on the date SeniorCare coverage starts, in order for SeniorCare to fully cover my medical services (except for emergency or urgently-needed services), all of my health care must be provided or arranged by SeniorCare. 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 SeniorCare and other services contained in my SeniorCare 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. I also acknowledge that SeniorCare will release my information, including my prescription drug 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 State law where I live) on this application means that I have read and understand the contents of this Change form. 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 SeniorCare 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: _____

MAIL: Scott & White Health Plan
Mail Stop: MS-A4-126
Attention: Retention Dept.
1206 West Campus Drive
Temple, TX 76502

FAX: Scott & White Health Plan
Attention: Retention Dept.
254-298-3567

EMAIL: swhpseniors@sw.org

Office Use Only:
Tracking Number: _____
(*Example: time / mo/date/yr / first & last initials (0915 11052015 ES)*

Division #: _____ Plan Representative #: _____ Area #: _____

Effective Date of Coverage: _____ ☐ IEP ☐ AEP ☐ SEP (type): _____

Confirmed Current Plan Information: (initials) _____ Date: _____

This information is available for free in other languages. Please contact our customer services number at 1-866-334-3141, Monday through Sunday, 8 a.m. to 8 p.m. TTY users call 1-800-735-2989 for additional information. Esta información está disponible para libre en otros idiomas. Contacte por favor nuestro número de servicios de atención al cliente en lunes 1-866-334-3141, por el domingo, 8 de la mañana a 8 de la tarde, usuarios de TTY llaman 1-800-735-2989 para la información adicional.Scott & White Health Plan is a HMO plan with a Medicare contract. Enrollment in SeniorCare depends on contract renewal.

H4564_CHANGEFORM Accepted