

# LifeWorks Advantage Enrollment Receipt



**To be completed if enrolling in-person with a Licensed Medicare Benefits Consultant.**

Please keep this as a record of your completed application to join LifeWorks Advantage. This receipt is not a guarantee of enrollment. If your membership is approved, you will receive letters and ID cards to your specified address.

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Applicant Name

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Proposed Effective Date

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Current Plan Name

This Plan listed above will be replaced by LifeWorks Advantage on the Proposed Effective Date

Yes or  No

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Enrollment Confirmation Number

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Low Income Subsidy Level (as defined by CMS)

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Medicaid Status

\*If you lack a Low Income Subsidy, Medicaid, or another cost-lowering program, you are responsible for all cost-sharing amounts on LifeWorks Advantage. An overview of the plan costs are located in the Summary of Benefits.

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## Prescription List

Rx Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Qty: \_\_\_ Frequency: \_\_\_\_\_

Rx Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Qty: \_\_\_ Frequency: \_\_\_\_\_

Rx Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Qty: \_\_\_ Frequency: \_\_\_\_\_

Rx Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Qty: \_\_\_ Frequency: \_\_\_\_\_

Rx Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Qty: \_\_\_ Frequency: \_\_\_\_\_

Rx Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Qty: \_\_\_ Frequency: \_\_\_\_\_

Rx Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Qty: \_\_\_ Frequency: \_\_\_\_\_

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## LifeWorks Advantage Enrollment Receipt continued

### Appointment Checklist

The following information was reviewed and explained to the client on the date below. Any and all questions were answered prior to the end of the appointment.

- Plan Type – *Reviewed what type of plan this is*
- Network – *Reviewed plan network (doctors, specialists, providers, etc.)*
- Prescription Drug Coverage
- Star Ratings
- Costs/Coverage – *Premium, max out-of-pocket, copayments, co-insurance*

All plan materials and contact information for the plan and the agent are being left for the client to reference after the date below. This form does not obligate you to enroll into a plan, affect your current enrolment, or enroll you in a Medicare plan.

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### Call your Medicare Benefits Consultant if you have any questions:

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Plan Number and PBP: \_\_\_\_\_

RxBin: \_\_\_\_\_

Rx PCN: \_\_\_\_\_

RxGRP: \_\_\_\_\_

Today's Date: \_\_\_\_\_

### Confirmation of receipt:

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**(Patient signature)**