ship state health insurance assistance programs
NATIONAL NETWORK

LOCAL HELP FOR PEOPLE WITH MEDICARE

AREA AGENCY ON AGING
REGION ONE, INCORPORATED

MEDICARE ADVANTAGE or DRUG PLAN 2015 ENROLLMENT AGREEMENT

I authorize the Benefits Assistance Program (BAP) of the Area Agency on Aging, Region One, part of the State Health Insurance Assistance Program (SHIP), to enroll me in the following Medicare Advantage Plan or Drug Plan:

Name of Company: _____

Name of Plan: _____

Plan Number: _____

BAP (Benefits Assistance Program) will follow your enrollment instructions and fill in the enrollment form with information that you have provided. BAP will assume that the information that you provide is complete, truthful and accurate. BAP assumes no responsibility for your decisions and you agree that the Area Agency on Aging, Region One is not responsible for any liability arising out of assisting you with your enrollment.

_____

Printed Name Date

_____

Signature Telephone number

In addition to the personal information previously submitted on the Counseling Tool, the following information is needed for your on-line enrollment:

Permanent Residence: _____
Street

_____ _____ _____
City State Zip Code

Mailing Address: _____
(if different from above) Street

_____ _____ _____
City State Zip Code

Emergency Contact: _____
(Optional) Name

_____ _____
Relationship to You Phone Number

Preference for Primary Care Physician: _____

*Mail completed form **with signature to:*** Area Agency on Aging, Region One,
Benefits Assistance Program 1366 E. Thomas Rd., Suite 108 Phoenix, AZ 85014