

SELECT PLAN

Zing Choice IL (HMO)

STATUS

Current Member New Referral

Zing Health is a HMO plan sponsor with a Medicare contract. Enrollment in Zing Health depends on contract renewal. Zing Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. By providing the following information, you authorize a Zing Health associate or contracted agent to call or contact you now or during the next enrollment period when benefits information is available.

MEMBER/PROSPECTIVE MEMBER CONTACT INFORMATION

Name:			Date of Birth:
Address:			Apartment #:
City:	State:	Zip Code:	County:
Phone #:	Email (Optional):		
Consent Method: <input type="checkbox"/> Phone Call/Representative <input type="checkbox"/> Consent to Contact Card <input type="checkbox"/> Online Form			

ELIGIBILITY INFORMATION

Member ID#:	Plan Change: <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you 65 years old? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, when?
Do you have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No
HICN/MBI:	Medicaid #:

PLAN EFFECTIVE DATES

Part A:	LIS Level:
Part B:	Percentage:
Part D:	QMB: <input type="checkbox"/> Yes <input type="checkbox"/> No

HOW DID YOU HEAR ABOUT US?

General <input type="checkbox"/> Member Referral: <input type="checkbox"/> Employee Referral:	Event <input type="checkbox"/> Event Event Date: Event Name: Event Code: Agent:
Web & Social Media <input type="checkbox"/> Facebook <input type="checkbox"/> Twitter <input type="checkbox"/> LinkedIn <input type="checkbox"/> Instagram <input type="checkbox"/> Google <input type="checkbox"/> Web Search	Advertisement <input type="checkbox"/> Printed Material <input type="checkbox"/> Radio <input type="checkbox"/> Television <input type="checkbox"/> Billboard <input type="checkbox"/> Newspaper <input type="checkbox"/> Bus/Bus Shelter Ad

NOTES:

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SUBMITTER INFORMATION

Name:	Department:
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