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MedicareRx Prescription Drug Coverage

OMB No. 0938-1378 Expires:7/31/2023

ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN

Who can use this form?
People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:
• Be a United States citizen or be lawfully present in the U.S.
• Live in the plan's service area

Important: To join a Medicare Advantage plan, you must also have both:
• Medicare Part A (Hospital Insurance)
• Medicare Part B (Medical Insurance)

When do I use this form?
You can join a plan:
• Between October 15–December 7 each year (for coverage starting January1)
• Within 3 months of first getting Medicare
• In certain situations where you're allowed to join or switch plans

Visit www.Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?
• Your Medicare Number (the number on your red, white, and blue Medicare card)
• Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:
• If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
• Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?
Send your completed and signed form to:

Network Health
Attn: Medicare Enrollment
1570 Midway Pl.,
Menasha, WI 54952

Once we process your request to join, we'll contact you.

How do I get help with this form?
Call Network Health Medicare Advantage Plan at 800-983-7587 (TTY 800-947-3529).

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048).

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Please contact Network Health Medicare Advantage Plans
if you need information in another language or format (Braille).

To Enroll in a Network Health Medicare Advantage Plan, Please Provide the Following Information

I would like to enroll in:

Network Health Medicare Explore with Pharmacy (HMO)
$11 per month

Plan Effective Date
I would like my coverage to begin on:
____/___/_____
(MM / DD / YYYY)

LAST Name:	**FIRST Name**:	**Middle Initial**:

Birth Date: (____/____/_____) (MM / DD / YYYY)	**Sex**: ☐ M ☐ F	**Home Phone Number**:	**Alternate Phone Number**:

Permanent Residence Street Address (P.O. Box is not allowed):

City:	**County**:	**State**:	**Zip Code**:

Mailing Address (only if different from your Permanent Residence Address):

Street Address: _____ City: _____

State: _____ Zip Code: _____

Email Address:

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card
- OR –
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Name (as it appears on your Medicare Card)
_____

Medicare Number
_____

Is Entitled To	Effective Date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay Network Health Medicare Advantage Plans the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75 percent or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option.

☐ Get a bill each month. Between the 15th and 20th of each month, we will send you a billing statement indicating your balance due.

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a **VOIDED** check or provide the following. The monthly premium will be deducted around the 7th of each month.

Account Holder Name: _____

Bank Routing Number: __ __ __ __ __ __ __ __ __ Bank Account Number: _____

Account type: ☐ Checking ☐ Savings

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB*)* benefit check. Deduction applies to plan premium only and does not include the supplemental dental rider.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include the amount for one month premium due from your enrollment effective date to the point withholding begins. You will receive a paper bill for any additional months that are still due. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please Read and Answer These Important Questions

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Network Health Medicare Explore?

☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage.

Name of Other Coverage: _____ ID # for This Coverage: _____ Group # for This Coverage: _____

2. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If "yes," please provide the following information.

Name of Institution: _____

Address and Phone Number of Institution (number and street): _____

3. Are you enrolled in your state Medicaid program? ☐ Yes ☐ No

If yes, please provide your Medicaid number: _____

4. Do you or your spouse work? ☐ Yes ☐ No

Please provide the name of a personal doctor (also referred to as a primary care practitioner or PCP):

_____

Please check the box below if you would prefer us to send you information in an accessible format.

☐ Large print

☐ Braille

Please contact Network Health Medicare Advantage Plans at 800-983-7587 (TTY 800-947-3529) if you need information in a language other than English. Our office hours are Monday–Friday from 8 a.m. to 8 p.m.

STOP
Please Read This Important Information

If you currently have health coverage from an employer or union, joining a Network Health Medicare Advantage Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join a Network Health Medicare Advantage Plan. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

IMPORTANT: Please Read and Sign Below

By completing this enrollment application, I agree to the following.

Network Health Medicare Explore with Pharmacy is a Medicare Advantage plan and has a contract with the federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.

Network Health Medicare Advantage Plans serve a specific service area. If I move out of the area that Network Health Medicare Explore with Pharmacy serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Network Health Medicare Explore with Pharmacy, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from Network Health Medicare Advantage Plans when I get it to know which rules I must follow to get coverage with this Medicare Advantage 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 Network Health Medicare Advantage Plan coverage begins, I must get all of my health care from Network Health Medicare Advantage plan, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Network Health Medicare Advantage Plans provide refunds for all covered benefits, even if I get services out-of-network. Services authorized by Network Health Medicare Advantage Plans and other services contained in my Network Health Medicare Advantage Plan *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR NETWORK HEALTH MEDICARE ADVANTAGE PLANS WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Network Health Medicare Advantage Plans, he/she may be paid based on my enrollment in Network Health Medicare Advantage Plan.

Release of Information: By joining this Medicare health plan, I acknowledge that Network Health Medicare Advantage Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Network Health Medicare Advantage 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.

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Individual Enrollment Request Form

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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.

Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information. Please send the appropriate paperwork showing you are the authorized representative within two weeks of submitting the application.

Name: _____

Address: _____

Phone Number: (_____) _____

Relationship to Enrollee: _____

Optional Supplemental Dental.

☐ **YES,** I want to enroll in Delta Dental of Wisconsin Supplemental Benefit. I understand that this is an optional benefit and that if I enroll by selecting "Yes", I will be billed an additional **$38** monthly premium by Network Health.

☐ **NO,** I do not want to enroll in this optional supplemental dental plan.

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Agent ID#: _____

Plan ID#: _____

Effective Date of Coverage: _____

ICEP/IEP: ☐ AEP: ☐ SEP (type): _____ Not Eligible: ☐

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Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.

☐ I recently was released from incarceration. I was released on (insert date) _____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.

☐ I recently left a PACE program on (insert date) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.

☐ I am leaving employer or union coverage on (insert date) _____.

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Attestation of Eligibility for an Enrollment Period

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

☐ I was enrolled in a Special Needs Plan (SNP), but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements apply to you or you're not sure, please contact Network Health Medicare Advantage Plans at 800-378-5234 (TTY 800-947-3529) to see if you are eligible to enroll. We are open Monday–Friday, from 8 a.m. to 8 p.m. From October 1 to March 31, we are available every day from 8 a.m. to 8 p.m.