# Network Health Medicare Advantage Plans

OMB No. 0938-1378 Expires:7/31/2024

## ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (Part C)

**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 three months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit 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.

**Individuals experiencing homelessness**
- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

**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.
- If you have a monthly premium, 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 users can call 800-947-3529.

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

En español: Llame a Network Health Medicare Advantage Plan al 800-983-7587 (TTY 800-947-3529) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. **IMPORTANT Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.**

# Network Health Prime (MSA)

OMB No. 0938-1378
Expires: 7/31/2024

## Individual Enrollment Request Form

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

### Section 1 – All fields on this page are required

**I would like to enroll in:**

☐ Network Health Prime (MSA) **$0** 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**: ☐ Male ☐ Female | **Home Phone Number**: (     ) | **Alternate Phone Number**: (     ) |
|---|---|---|---|

**Permanent Residence Street Address (Don't enter a PO Box)**:

| **City**: | **County**: | **State**: | **Zip Code**: |
|---|---|---|---|
| | | | |

**Mailing Address** (only if different from your Permanent Residence Address, PO Box allowed):

Street Address: ________________________________________ City: ______________________________

State: _______________ Zip Code: ______________________

### Optional Supplemental Dental

☐ **YES,** I want to enroll in the 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 **$42** monthly premium by Network Health.

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

### Please Provide Your Medicare Insurance Information

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.

### Please Answer These Important Questions

1. To enroll in Network Health Prime, you may not have other health coverage as described below. Please answer each of the following questions.
   A. Are you enrolled in your state Medicaid program? ☐ Yes ☐ No
   B. Are you receiving Medicare Hospice benefits? ☐ Yes ☐ No
   C. Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits or other health benefits that cover all or part of the annual Medicare MSA deductible. If you have any other such coverage, you aren't eligible to enroll in Network Health Prime.

# Network Health Prime (MSA)
# Individual Enrollment Request Form

Will you have other health coverage in addition to Network Health Prime? ☐ Yes ☐ No

If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage so we can decide if you are eligible to enroll in Network Health Prime.

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

2. Will you reside in the United States for at least 183 days during each year you are enrolled in Network Health Prime? ☐ Yes ☐ No

3. Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

**Answering these questions is your choice. You can't be denied coverage because you don't fill them out.**

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

Select one if you want us to send you information in an alternate format or a language other than English.
☐ Large print ☐ Braille ☐ Audio CD ☐ Language other than English Language needed ____________________
Please contact Network Health Medicare Advantage Plan at 800-983-7587 if you need information in an accessible format other than what's listed above. Our office hours are Monday–Friday, from 8 a.m. to 8 p.m. TTY users can call 800-947-3529.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.
☐ No, not of Hispanic, Latino/a or Spanish origin ☐ Yes, Mexican, Mexican American, Chicano/a ☐ Yes, Cuban ☐ Yes, Puerto Rican ☐ Yes, another Hispanic, Latino/a, or Spanish origin ☐ **I choose not to answer**

What's your race? Select all that apply.
☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ **I choose not to answer**

## IMPORTANT: Please read and sign on the next page

**By completing this enrollment application, I agree to the following:**

Network Health Prime 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 be in only 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. It is my responsibility to inform you of any health coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. I may leave this plan ("disenroll") during the Annual Enrollment Period that is October 15 through December 7 of every year (effective the following January 1) or under certain limited special circumstances, by sending a request in writing to Network Health Prime. If I choose a Medicare MSA plan and haven't before joined an MSA plan, then change my mind, I may cancel my enrollment by December 15 of the same year by contacting my plan to cancel my enrollment request. I understand that my enrollment into an MSA plan isn't complete until the bank account is established. I understand that I am enrolling in a plan that doesn't pay for Medicare covered services until a high deductible is met, but Network Health Prime allows me to use funds in my MSA account to pay for health services. Withdrawals made from the MSA bank account aren't taxed when used for IRS-qualified medical expenses. I would owe income tax and up to a 50 percent penalty for withdrawals used for non-medical expenses. After the deductible is met the plan pays 100 percent of Medicare-covered services.

If I have any questions regarding the initial set-up of my MSA bank account or any of the information in this enrollment form, I should contact Network Health at 800-983-7587 (TTY 800-947-3529).

# Network Health Prime (MSA)
# Individual Enrollment Request Form

Network Health Prime serves a specific service area. If I move out of the area that Network Health Prime 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 Prime, 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 Prime when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.

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

I understand that if I disenroll before the end of the plan year (December 31), Network Health Prime may debit my MSA bank account for a prorated share of the current year's deposit to be returned to Medicare. The debit amount is based on the number of months left in the year after the disenrollment date. I understand that, if I die, my estate will be responsible for any money owed to Medicare. My estate keeps any amount over what is owed to Medicare.

**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 Network Health Prime will release my information 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 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: ______________________________

Keeping records – As an authorized representative, it is important that you keep records of when funds in the MSA account are used, as well as how funds are used.

## Office Use Only

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

Agent ID#: ______________________________

Date application was completed with agent/broker: ______________________________

Application left with prospect to mail: ☐ Yes ☐ No

How was enrollment completed: ☐ Telephonic ☐ Virtual ☐ In-Person

ICEP/IEP: _______ AEP: _______ SEP (type): ______ Not Eligible: _______

# Network Health Prime (MSA)
# Individual Enrollment Request Form

PRIVACY ACT STATEMENT The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

# Master Signature Card — Medical Savings Account
# The Bank of New York Mellon

Name (1): ____________________ Account Number: ____________________

SSN: ____________________ Date: ____________________

Name (2): ____________________ (Please print name of any additional "Authorized Signature" signed below.)

**REQUEST FOR TAX CERTIFICATION**

Under penalties for perjury, I certify that the SSN number shown on this form is my correct taxpayer identification number and I am a citizen or resident of the United States.

The IRS does not require you to consent to any provision of this document.

By signing this card and opening a Medical Savings Account with The Bank of New York Mellon (the "Bank"), I agree: (a) To be bound by the Deposit Agreement & Disclosure Statement applicable to the Medical Savings Account established by this card, as that agreement may be amended from time to time; (b) To be bound by the Bank's agreements and disclosures applicable to any additional accounts that I establish with the Bank in the future as an individual, custodian, or single trustee.

This Master Signature Card Agreement will remain in effect as long as I continuously maintain at least one covered account with the Bank.

**Authorized Signature(s):** Please sign your authorized signature(s) in the boxes below.

1. 

2. 

In accordance with the US Patriot Act we are required to verify the identity all of our account holders. To do so most efficiently please provide a residential address if this kit was mailed to a P.O. Box:

Street Address: ____________________

City: ____________________ State: ____________________ Zip: ____________________

**Beneficiary Designation Form**

I hereby certify that, if I die before distribution has been completed, the value of my account shall be distributed to the person(s) named below. If all Primary Beneficiaries die before me, the Contingent Beneficiary(ies) named below will receive the value of my account

**Primary Beneficiary(ies)**

| Name | | Name | |
|---|---|---|---|
| Address | | Address | |
| City, State, and Zip | | City, State, and Zip | |
| Relationship | SSN | Relationship | SSN |
| Date of Birth | Percent (%) | Date of Birth | Percent (%) |

**Contingent Beneficiary(ies)**

| Name | | Name | |
|---|---|---|---|
| Address | | Address | |
| City, State, and Zip | | City, State, and Zip | |
| Relationship | SSN | Relationship | SSN |
| Date of Birth | Percent (%) | Date of Birth | Percent (%) |

**Important:**
Return the completed form to: BenefitWallet, P.O. Box 18017, Norfolk, VA 23501-1845

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**Multi-Language Insert – REQUIRED INFORMATION**

**Multi-language Interpreter Services**

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 800-378-5234 (TTY 800-947-3529). Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 800-378-5234 (TTY 800-947-3529). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 800-378-5234 (TTY 800-947-3529)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 800-378-5234 (TTY 800-947-3529)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 800-378-5234 (TTY 800-947-3529). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 800-378-5234 (TTY 800-947-3529). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 800-378-5234 (TTY 800-947-3529) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 800-378-5234 (TTY 800-947-3529). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 800-378-5234 (TTY 800-947-3529) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 5234-378-800 (TTY 3529-947-800). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 800-378-5234 (TTY 800-947-3529). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 800-378-5234 (TTY 800-947-3529) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 800-378-5234 (TTY 800-947-3529). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portugués:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 800-378-5234 (TTY 800-947-3529). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 800-378-5234 (TTY 800-947-3529). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 800-378-5234 (TTY 800-947-3529). Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、800-378-5234 (TTY 800-947-3529) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

**Hmong:** Peb muaj cov kev pab cuam kws txhais lus pab dawb los teb tej lus nug uas koj muaj hais txog peb li kev noj qab hauv huv los sis lub phiaj xwm tshuaj kho mob. Kom tau txais kws txhais lus pab dawb, tsuas yog hu rau peb ntawm tus xov tooj 800-378-5234 (TTY 800-947-3529). Qee tus neeg uas hais Askiv/Yam Lus koj paub tuaj yeem pab tau rau koj. Qhov no yog kev pab dawb.