Short Enrollment Request Form

Name:	**Medicare Number:**
Home Phone Number:	Date of Birth:
Permanent Street Address (P.O. Box is not allowed):	Apt. #:

City:	County:	State:	ZIP Code:

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

Street Address: City: State: ZIP Code:

Please fill out the following.

I am currently a member of:

Northeast Wisconsin Plans:

- ☐ Network Platinum*Plus* (PPO) **$89** per month
- ☐ Network Platinum*Premier* (PPO) $**195** per month
- ☐ Network Platinum*Select* with Pharmacy (PPO) **$0** per month
- ☐ Network Platinum*Choice* with Pharmacy (PPO) **$25** per month
- ☐ Network Platinum*Plus* with Pharmacy (PPO) $**122** per month
- ☐ Network Platinum*Premier* with Pharmacy (PPO) **$295** per month
- ☐ Network*Cares* with Pharmacy (PPO SNP) $**0** per month

Southeast Wisconsin Plans:

- ☐ Network Health Medicare Go (PPO) $**0** per month Network
- ☐ Health Medicare Anywhere (PPO) $**25** per month

Plan Effective Date

I would like my new plan to begin on:

_____/____/_____

I would like to change to:

Northeast Wisconsin Plans:

- ☐ Network Platinum*Plus* (PPO) **$89** per month
- ☐ Network Platinum*Premier* (PPO) $**195** per month
- ☐ Network Platinum*Select* with Pharmacy (PPO) **$0** per month
- ☐ Network Platinum*Choice* with Pharmacy (PPO) **$25** per month
- ☐ Network Platinum*Plus* with Pharmacy (PPO) $**122** per month
- ☐ Network Platinum*Premier* with Pharmacy (PPO) **$295** per month
- ☐ Network*Cares* with Pharmacy (PPO SNP) $**0** per month

Southeast Wisconsin Plans:

- ☐ Network Health Medicare Go (PPO) $**0** per month Network
- ☐ Health Medicare Anywhere (PPO) $**25** per month

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Please check the box below if you would prefer us to send you information in a language other than English or 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 an accessible format or language other than what is listed above. Our office hours are Monday–Friday, from 8 a.m. to 8 p.m.

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 **$35** monthly premium by Network Health.

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

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

_____

Paying Your Plan Premium

If we determine you owe a late enrollment penalty, (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay 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.

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.

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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 for this benefit. 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: _____ Account type: ☐ Checking ☐ Savings
Bank Routing Number: __ __ __ __ __ __ __ __ __ Bank Account Number: _____

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB*)* benefit check.

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 all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

STOP

Please Read This Important Information

Please Read and Sign Below

Network Health Insurance Corporation is a plan that has a contract with the Federal government.

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

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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 Insurance Corporation 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. 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 people with Medicare aren't 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 Insurance Corporation coverage begins, I must get all of my health care from Network Health Insurance Corporation except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Network Health Insurance Corporation and other services contained in my Network Health Insurance Corporation Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR NETWORK HEALTH INSURANCE CORPORATION WILL PAY FOR THE SERVICES.**

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.

Name: _____

Address: _____

Phone Number: (_____) _____

Relationship to Enrollee: _____

network health **Attestation of Eligibility for an Enrollment Period** MedicareRx Prescription Drug Coverage

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) _____.

network health **Attestation of Eligibility for an Enrollment Period** MedicareRx Prescription Drug Coverage

☐ 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 a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural 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.