network health

NEWI Premium Plans

MedicareRx Prescription Drug Coverage

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

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.

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 800-947-3529).

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

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Section 1 – All fields on this page are required

I would like to enroll in:

- ☐ Network Platinum*Choice* (PPO) **$31** per month
- ☐ Network Platinum*Plus* Pharmacy (PPO) **$125** per month
- ☐ Network Platinum*Premier* Pharmacy (PPO) **$298** per month
- ☐ Network Platinum*Plus* (PPO) **$51** per month
- ☐ Network Platinum*Premier* (PPO) **$177** 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: _____

Email Address:

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 This Important Question

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 a Network Health Medicare Advantage Plan?

☐ 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: _____

Paying Your Plan Premium and/or Late Enrollment Penalty

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 have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DO NOT pay Network Health Medicare Advantage Plan the Part D-IRMAA.
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 prior to your effective date. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Section 2 – This information is optional

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

Do you work? ☐ Yes ☐ No Does 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 one of the boxes below if you would prefer us to send you information in an accessible format.

☐ Large print ☐ Braille ☐ Language other than English Language needed _____

Please contact Network Health Medicare Advantage Plan 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.

IMPORTANT: Please read and sign on the next page

- I must keep both Hospital (Part A) and Medical (Part B) to stay in a Network Health Medicare Advantage Plan.
- By joining this Medicare Advantage Plan, I acknowledge that Network Health Medicare Advantage Plan will share my information with Medicare, who may use it to track my enrollment, to make payments and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- 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 are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.

• I understand that when my Network Health Medicare Advantage Plan coverage begins, I must get all of my medical and prescription drug benefits from Network Health Medicare Advantage Plan. Benefits and services provided by Network Health Medicare Advantage Plan and contained in my Network Health Medicare Advantage Plan *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Network Health Medicare Advantage Plan will pay for benefits or services that are not covered.
• I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 by 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 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 **$39** 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#: _____

Application left with prospect to mail: ☐ Yes ☐ No

Effective Date of Coverage: _____

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

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.

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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.