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Independent Health®

MEDICARE ADVANTAGE 2021 INDIVIDUAL ENROLLMENT APPLICATION

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 January 1)
- Within 3 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.
- 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:
Independent Health
Attn: Membership, Government Operations
P.O. Box 610
Williamsville, NY 14231-9909

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

How do I get help with this form?

Call Independent Health at (716) 635-4900 or 1-800-958-4405 toll-free. TTY users can call 711.

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

En español: Llame a Independent Health at (716) 635-4900 or TTY: 711 o a Medicare gratis al 1-800-958-4405 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

MEDICARE ADVANTAGE 2021 INDIVIDUAL ENROLLMENT APPLICATION

If you have any questions about our plans, need help filling out this application, or need information in another format (Braille), please call (716) 635-4900 or 1-800-958-4405 toll-free (TTY: 711): **October 1–December 7:** Monday–Sunday, 8 a.m.–8 p.m.; **December 8–September 30:** Monday–Friday, 8 a.m.– 8 p.m.

Independent Health

Preferred Effective Date (MM/DD/YYYY) _____

SECTION 1 **SELECT THE PLAN YOU WANT TO JOIN:** All fields on this page are required (unless marked optional)

PLEASE SELECT ONLY ONE PLAN

☐ **Independent Health's Encompass 65® Element HMO** (with prescription coverage) H3362-038: $0 monthly premium
☐ **Independent Health's Encompass 65® Core HMO** (with prescription coverage) H3362-033: $65 monthly premium
☐ **Independent Health's Encompass 65® Basic HMO** (with prescription coverage) H3362-017: $125 monthly premium

☐ **Independent Health's Medicare Passport® Advantage PPO** (with prescription coverage) H3344-005: $99 monthly premium
☐ **Independent Health's Medicare Passport® Prime PPO** (with prescription coverage) H3344-010: $215 monthly premium

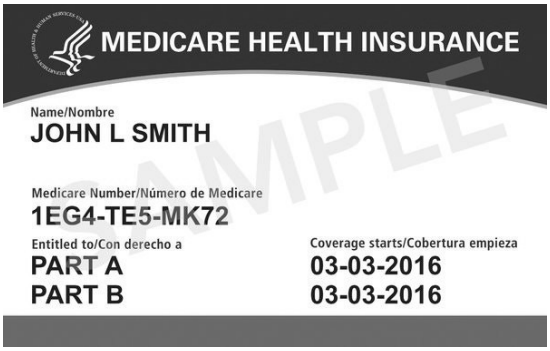
☐ **Independent Health's Encompass 65® HMO *(without prescription coverage)*** H3362-016: $0 monthly premium

☐ **Optional Supplemental Dental**: $25 monthly premium

YOUR MEDICARE INFORMATION

Name (as it appears on your Medicare card):
_____

Medicare number: _____
Entitled to: Effective Date:
HOSPITAL (Part A) _____
MEDICAL (Part B) _____



PLEASE TELL US ABOUT YOURSELF

Last Name _____ First Name _____ Initial _____
Date of Birth (month/day/year) _____ Gender ☐ M ☐ F ☐ Mr. ☐ Mrs. ☐ Ms.
Email Address (optional)* _____

**By providing your email address, you are agreeing to receive email communications from Independent Health.*

PERMANENT RESIDENCE STREET ADDRESS (P.O. BOX IS NOT ALLOWED):

Street/Apartment # _____
City _____ State _____ County _____ Zip Code _____
Home Telephone (area code and number) _____
Alternate Telephone (area code and number) _____

MAILING ADDRESS (ONLY IF DIFFERENT FROM PERMANENT ADDRESS):

Street/Apartment # _____
City _____ State _____ County _____ Zip Code _____

IN CASE OF EMERGENCY, PLEASE CONTACT (OPTIONAL):

Last Name _____ First Name _____
Telephone (area code and number) _____ Relationship _____

ANSWER THESE IMPORTANT QUESTIONS

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Independent Health? ☐Yes ☐No
Name of other coverage: _____
Member number for this coverage: _____
Group number for this coverage: _____

PAYING YOUR PLAN PREMIUM — Please read important information on the back of this application.

How would you like to pay your monthly Medicare plan premium?

☐ Bill me by mail each month.
☐ Deduct my premium payment from my checking account each month through Electronic Funds Transfer (EFT).
Please include a voided check with this application.
Withhold my premium payment amount from my:
☐ Social Security ☐ RRB payment[1,2]

[1] Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (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.)

[2] If you enrolled in the **EPIC fee plan,** we recommend not selecting Social Security Deduction or EFT.

Note: You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT), or credit card 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). DON'T pay Independent Health the Part D-IRMAA.

SECTION 2 PLEASE READ AND ANSWER THESE QUESTIONS All fields on this page are optional. Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

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

If YES, please list the institution's name, address, phone number and date of admission.

Name _____ Street _____ Suite# _____
City _____ State _____ Zip Code _____
Telephone (area code and number) _____ County _____ Date of Admission _____

2. Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' Compensation or VA benefits? ☐ Yes ☐ No

If YES, what kind of insurance do you have? _____ What is the name of your insurance? _____

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

4. I want the following materials via electronic access:

☐ Annual Notice of Change Email Address: _____

5. Please check one of the boxes below if you would prefer us to send you information in an accessible format.

☐ Large Print ☐ Braille ☐ Audio CD _____

Please contact Independent Health at 1-800-665-1502 (TTY: 711) if you need information in an accessible format other than what's listed above. Our office hours are October 1 – March 31: Monday – Sunday, 8 a.m. – 8 p.m.; April 1- September 30: Monday – Friday, 8a.m.- 8p.m.

PLEASE LIST A PRIMARY CARE PHYSICIAN (PCP), CLINIC OR HEALTH CENTER FROM THE PROVIDER DIRECTORY

Note: Required for all Independent Health Plans.

Physician's Last Name _____ Physician's First Name _____

Physician's Address _____ Current Patient ☐ Yes ☐ No

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) _____.
- ☐ 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 applies to you or you're not sure, please contact Independent Health at (716) 635-4900 or 1-800-958-4405 toll-free (TTY 711): to see if you are eligible to enroll. We are open October 1–December 7: Monday – Sunday, 8 a.m.– 8 p.m.; December 8 – September 30: Monday – Friday, 8 a.m.– 8 p.m.

ENROLLEE AUTHORIZATION — Please read important information on the back of this application.

I understand that my signature (or the signature of the person 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 from Medicare.

Signature _____ **Today's Date** _____

If you are the authorized representative, you must sign above and fill out these fields:

Last Name _____ First Name _____ Initial _____

Street/Apartment # _____

City _____ State _____ County _____ Zip Code _____

Home Telephone (area code and number) _____ Relationship to Enrollee _____

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

Effective Date of Coverage: _____ Location: _____

Plan ID #: _____ ICEP/IEP: _____ AEP: _____ SEP (type): _____ OEP: _____ OSD: _____

IMPORTANT: READ AND SIGN ON THE PREVIOUS PAGE

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

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Independent Health's plan.
- By joining this Medicare Advantage Plan, I acknowledge that Independent Health 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 Independent Health coverage begins I must get all of my medical and prescription drug benefits from Independent Health. Benefits and services provided by Independent Health and contained in my Independent Health "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Independent Health will pay for benefits or services that are not covered.

Out-of-network/non-contracted providers are under no obligation to treat Independent Health members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% 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 does not cover.

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

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.