OMB No. 0938-1378
Expires: 12/31/2026

MEDICARE ADVANTAGE 2026 GROUP ENROLLMENT APPLICATION

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

To Enroll in an Independent Health group plan, please provide the following information:			
Employer or Union Name:	Group #:	Effective Date:	
Plan Name:			
LAST name: FIRST name: Middle Initial:			☐ Mr. ☐ Mrs. ☐ Ms.
Birth date: (MM/DD/YYYY) (_____ /_____ /_____)	Sex: ☐ M ☐ F	Home Phone Number: ( )	
Permanent Residence street address (P.O. Box is not allowed):			
City:	County:	State:	ZIP Code:
Mailing address, if different from your permanent address (P.O. Box allowed): Street address: City: State: ZIP Code:			

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.	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

Independent Health is a Medicare Advantage organization with a Medicare contract offering HMO, HMO-SNP, HMO- POS and PPO plans. Enrollment in Independent Health depends on contract renewal.

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Please read and answer these important questions:

1. Are you the retiree? ☐ Yes ☐ No
If yes, retirement date (month/day/year):_____
If no, name of retiree:_____

2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No
If yes, name of spouse: _____
Name(s) of dependent(s): _____
_____

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

4. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State Pharmaceutical Assistance programs.
Will you have other prescriptiondrug coverage in addition to Independent Health? ☐Yes ☐No
If "yes,", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____ Member number for this coverage: _____

5. 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 & Phone Number of Institution (number and street):_____
_____

Please choose a Primary Care Physician (PCP) from the Provider Directory (note: required for all plans):
Physician's Last Name_____Physician's First Name_____
Physician's Address_____Current Patient ☐ Yes ☐ No

Please check one of the boxes below if you would prefer that we send you information in an accessible format. ☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD
Please contact Independent Health at 1-800-665-1502 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.; April1- September 30: Monday – Friday, 8a.m.- 8p.m. TTY users can call 711.

Email Communications

By checking the box(es) below and providing my email address, I agree to receive those documents and notifications electronically from Independent Health.
Email Address: _____

___Annual Notice of Change
___Part C and Part D (if applicable) Explanation of Benefits
___Communications related to plan details, status or transactions, promotional activities, health and wellness recommendations, health education and other information.

Text Messaging and Automated Phone Call Communications

By checking the box(es) below and providing my phone number, I expressly consent to receiving from Independent Health, its affiliates, and agents automated messages, including SMS/Text messages, phone calls using automated telephone dialer systems, or prerecorded voice or artificial voice messages at the number provided. Consent is not required as a condition of coverage. You may opt out of receiving these messages at any time by replying STOP to opt out of text messaging or calling Independent Health at 716-250-4401.

Mobile Phone Number: _____

I agree to receive the following from Independent Health regarding communications related to plan details, status or transactions, promotional activities, health and wellness recommendations, health education and other information.

___Automated Phone Calls ___Text Messages

Some messages may include health information that's specific to you. If you choose to receive emails and/or text messages, please know that electronic communication isn't always secure. There's a small risk that your messages could be seen or intercepted by someone else. By opting in, you understand and accept this risk. Message and data rates may apply.

Please Read and Sign Below
Independent Health 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. It is my responsibility to inform you of any prescription drug 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. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances. Independent Health serves a specific service area. If I move out of the area that Independent Health 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 Independent Health, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Independent Health 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 Independent Health coverage begins, I must get all of my health care from Independent Health, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Independent Health and other services contained in my Independent Health Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR INDEPENDENT HEALTH 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 Independent Health, he/she may be paid based on my enrollment in Independent Health.

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 Independent Health 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 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're the authorized representative, you must sign above and provide the following information:	
Name:	Address:
Phone Number:	Relationship to enrollee:

Office Use Only

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

Plan ID#: _____

Effective Date of Coverage:_____

ICEP/IEP:_____ AEP:_____ SEP (type):_____Not Eligible:_____