Special Enrollment Period (SEP)

SEP Reason Code:	
CMS Use Only:	

To Enroll in Medicare Advantage Prescription Drug Plan, Please provide the following contact information:

LAST Name: asd | FIRST Name: | MIDDLE Initial:

Birth Date:	Sex: ☐ M ☐ F	Phone Number:

Permanent Residence (P.O. Box is not allowed):
Address:

City:	State:	ZIP Code:

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

Address: | City: | State: | ZIP Code:

Benefits Information

Please take out your red, white and blue Medicare card to complete this section. In the spaces provided enter your Medicare Number (do not enter dashes).

Medicare Number:

_____

SAMPLE ONLY

Please provide your proposed effective date of coverage

Requested Effective Date: _____

Prescription drug coverage

Some individuals may have additional prescription drug coverage, including other private insurance, TRICARE, federal employee health benefits, VA benefits, or state pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to this plan? ☐ Y ☐ N

If you have other prescription drug coverage in addition to this plan, please provide the following:

Name of Additional Prescription Drug Coverage: _____

ID #: _____

Group #: _____

Other Information

Please see the additional questions below. Answering these questions is your choice.
You can't be denied coverage for not answering any of them.

Language or Accessible Format Preference

Specify the language if you want us to send you information in a language other than English.

_____

Specify the format if you want us to send you information in an accessible format.

_____

Employment Information

Do you work? ☐ Y ☐ N
Does your spouse work? ☐ Y ☐ N

Physician Selection (optional)

List your Primary Care Physician (PCP, clinic, or health center)

Email Information

Do you want to receive any of the following materials via email?

- ☐ Plan Formulary
- ☐ Summary of Benefits
- ☐ Evidence of Coverage

Email Address: ☐

Providing an email address authorizes us to contact you via email. Your email address will be handled consistent with our Privacy Policy.

Paying Your Plan Premium

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**

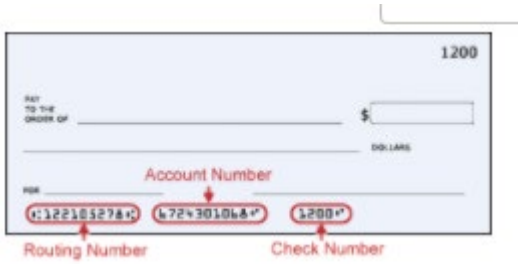
premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.

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 [Carrier] the Part D-IRMAA.

Please select a premium payment option:

☐ Get a Bill

☐ Electronic funds transfer (EFT) from your bank account each month



Account Holder Name: _____

Bank Account Number: _____

Bank Routing Number: _____

Account Type: ☐ Checking ☐ Savings

By selecting this option, I hereby authorize [Carrier Name] to withdraw from my checking/savings account amounts necessary to pay the premium owed by me under my [Carrier Name] contract. This authority will remain in effect until I notify [Carrier Name], or my bank, in writing to cancel it in such time as to afford the bank a reasonable opportunity to act on the cancellation.

☐ Credit Card

☐ Automatic deduction from your monthly Social Security/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.)

I get monthly benefits from: ☐ Social Security ☐ RRB

Please Read and Sign Below

IMPORTANT: Read and sign below:

☐ I understand that:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in .
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that 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).
- My 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 coverage begins, I must get all of my medical and prescription drug benefits from . Benefits and services provided by and contained in my "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor 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 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.

Privacy Act Statement

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

Signature/Confirmation Number:	Today's Date:

If you have been authorized to fill out this form on behalf of another individual, under the laws of the State where that individual resides, you must provide the following information. Upon request, you must be able to present [Carrier] [Plan name] and/or Medicare with documentation of your authority to represent the individual listed on this application

Name: _____

Address: _____

City: _____ State: _____ ZIP Code _____

Phone Number: (_____)_____- _____

Relationship to Enrollee _____

For Enrollments From a Sponsor's Enrollment Portal Only:

Agent ID: _____

Agent Name: _____

Agent Email: _____

Agent NPN: _____

Source ID: _____

Agency ID: _____

Agency Name: _____

Office Use Only:

Name of staff member (if assisted in enrollment):_____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP:_____ OEP:_____ AEP:_____ SEP (type):_____