HealthSun
HEALTH PLANS

2020 Enrollment Request Form

HealthSun Health Plans is an HMO plan with a Medicare contract. Enrollment in HealthSun Health Plans depends on contract renewal. You must continue to pay your Medicare Part B Premium. Benefits, premiums, and/or co-payments/co-insurance may change on January 1 of each year. HealthSun complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-336-2069. (TTY: 1-877-206-0500). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-336-2069. (TTY: 1-877-206-0500).

H5431_2020ENRAP_C Approved 09/03/2019

Proposed Effective Date ☐

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

To enroll in HealthSun Health Plans, please provide the following information:

Please check which HealthSun plan you want to enroll in:

Miami-Dade County	**Broward County**	**Palm Beach County**
☐ 001 HMO SunPlus Advantage $0 per month	☐ 012 HMO HealthAdvantage $0 per month	☐ 013 HMO HealthAdvantage $0 per month
☐ 006 HMO MediMax $28.50 per month	☐ 006 HMO MediMax $28.50 per month	☐ 014 HMO MediMax $28.50 per month

Last Name:	**First Name:**	**Middle Initial:**
Date of Birth: ____ ____ / ____ ____ / _____	Sex: ☐ M ☐ F	Home Phone Number: (_____) _____ - _____
Permanent Residence Street Address (PO Box not allowed):		
City:	County:	State: Zip:
Mailing Address (only if different from your Permanent Residence Address):		
City:	County:	State: Zip:
Emergency Contact Name:	**Emergency Contact Phone Number:**	
Relationship to you:	Alternate Phone Number:	
E-mail address (optional):		

Please choose your Primary Care Physician (PCP)

PCP Name:	**PCP ID Number:**
Group or Medical Center:	

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.

Paying Your Plan Premium

If we determine that 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, each month or quarterly. 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 the RRB. DO NOT pay HealthSun Health Plans the Part D-IRMAA. **You can pay your monthly plan premium** (including any late enrollment penalty that you currently have or may owe) by mail, each month or quarterly. 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 HealthSun Health Plans the Part D-IRMAA. **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 co-insurance. 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 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

☐ 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/RBR 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 premium.)

Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD)? ☐ **Yes** ☐ **No**

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

2. Will you have other prescription drug coverage in addition to HealthSun Health Plans? ☐ **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: _____

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

4. 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: _____ Phone Number: _____

Address of Institution (number and street: _____

5. Are you enrolled in your State Medicaid Program? ☐ **Yes** ☐ **No**
If yes, please provide your Medicaid number: _____

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in accessible format: ☐**Spanish** ☐**Creole** ☐**Braille** ☐**Audio Tape** ☐**Large Print** ☐**Other:**
Please contact HealthSun Health Plans at (877) 336-2069 if you need information in an accessible format or language other than what is listed above. Our office hours are 7 days a week from 8am to 8pm. TTY (877) 206-0500.

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between October 15 and 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 if the statement applies to you. You may also initial next to the statement that applies to you. By checking any of the following you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period.**

____ 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 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 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 recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's) on (insert date) _____.

____ 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 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 in/out of the facility on (insert date) _____.

____ I recently left a PACE program on (insert date) _____.

____ I recently moved to this plan's service area on (insert date) _____.

____ I recently returned to the U.S. after living permanently outside of the U.S on (insert date) _____.

____ I recently obtained lawful presence status in the U.S. I got this status on (insert date) _____.

____ I recently was released from incarceration. I was released on (insert date) _____.

____ I am leaving employer or union coverage on (insert date) _____.

____ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

____ 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.

____ Other: _____

If none of these statements applies to you or you're not sure, please contact HealthSun at 1-877-336-2069 (TTY users call 1-877-206-0500) to see if you are eligible to enroll. We are open 7 days week 8am to 8pm.

PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining HealthSun Health Plans could affect your employer or union health benefits. You could lose your employer or union health coverage if you join HealthSun Health Plans. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information

Please Read and Sign Below

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

HealthSun Health Plans ("HealthSun") 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 be in only 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 or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get 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 when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

HealthSun serves a specific service area. If I move out of the area that HealthSun 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 HealthSun, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from HealthSun 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 HealthSun coverage begins, I must get all my health care from HealthSun, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by HealthSun and other services contained in my HealthSun Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTHSUN 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 HealthSun, he/she may be paid based on my enrollment in HealthSun.

Release of Information: By joining this Medicare health plan, I acknowledge that HealthSun will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that HealthSun 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 by HealthSun or by Medicare.

Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:

If you have witnessed/verified the beneficiary's enrollment request, please complete below.

Name: _____ Phone Number: _____

Relationship to Enrollee: _____ Address: _____

Office Use Only:

Agent Signature: _____ Agent Print Name: _____

Plan Writing ID: _____ Group ID (if applicable: _____

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White Copy – Enrollment Yellow Copy – Agent Pink Copy – Member