



Member Plan Change Form Instructions

To make a change in the Medicare Advantage plan you have with HealthSun Health Plans, fill out the enclosed plan selection form to make your choice. Check off the plan you want, and sign the form. Then mail the completed form back to us.

You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

If you join our plan when you first enroll in Medicare, you can switch to another plan or get Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). If you're not happy with your choice in our plan, you can make a change during the first 3 months you have Medicare.

If you select another plan and we receive your completed selection form by the end of any month, your new benefit plan will generally begin on first of the following month. If we receive your completed selection form from October 15 – December 7, the effective date will generally be January 1.

Complete the attached form only if you wish to change plans.

To help you with your decision, we have also included a 2021 benefit overview for the available options.

If you have any questions, please call HealthSun Health Plans at 1-877-336-2069. TTY users should call 1-877-206-0500. We are open from October 1 through March 31, seven days a week from 8 a.m. to 8 p.m. (we close our offices on Thanksgiving and Christmas Day). From April 1 through September 30, we are available Monday through Friday from 8 a.m. to 8 p.m. (we close our offices on federal holidays).

HealthSun complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

H5431_CNGPBP_C_ENG Rev.20210528



2021 Plan Change Form
Switch from Plan to Plan within HealthSun Health Plans

Your Information			
Member Name:			
Member ID (ex. HSXXXXXX-XX):			
Home Phone Number:		Alternative Phone Number	
Permanent Street Address (P.O. Box is not allowed):			
City:	County:	State:	ZIP Code:
Mailing Address (only if different from your Permanent Street Address):			
City:	County:	State:	ZIP Code:
Communication Preferences			
<p>Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:</p> <p><input type="checkbox"/> Spanish <input type="checkbox"/> Other Language: _____</p> <p><input type="checkbox"/> Braille <input type="checkbox"/> Large Print <input type="checkbox"/> Audio CD</p> <p>Please contact HealthSun Health Plans at 1-877-336-2069 if you need information in an accessible format or language other than what is listed above. From October 1 through March 31, we are available seven days a week from 8 a.m. to 8 p.m. (we close on Thanksgiving and Christmas Day). From April 1 through September 30, we are available Monday through Friday from 8 a.m. to 8 p.m. (we close on federal holidays). TTY users should call 1-877206-0500.</p>			

Plan Selection

I want to transfer from my current plan to the plan I have selected below. I understand that if the plan receives this form by the end of any month, my new plan will generally be effective the 1st of the following month. If the plan receives this form during October 15 – December 7, the effective date will generally be January 1. Please check the appropriate box below (*check one*):

001 HealthAdvantage Plan (HMO) - Miami-Dade

Monthly Premium: \$0	Primary Care Visit Copay: \$0	Inpatient Hospital Copay: \$0	Emergency Room Copay: \$0
Out of Pocket Max: \$3,450	Specialist Visit Copay: \$0		Ambulance Copay: \$75

006 MediMax (HMO) - Miami-Dade & Broward

Monthly Premium: \$30.80	Primary Care Visit Copay: \$0	Inpatient Hospital Copay: \$0	Emergency Room Copay: \$0
Out of Pocket Max: \$3,450	Specialist Visit Copay: \$0		Ambulance Copay: \$0

012 HealthAdvantage Plan (HMO) - Broward

Monthly Premium: \$0	Primary Care Visit Copay: \$0	Inpatient Hospital Copay: \$0	Emergency Room Copay: \$75
Out of Pocket Max: \$3,450	Specialist Visit Copay: \$0		Ambulance Copay: \$200

013 HealthAdvantage Plan (HMO) - Palm Beach

Monthly Premium: \$0	Primary Care Visit Copay: \$0	Inpatient Hospital Copay: \$75 for days 1 – 5 and \$0 for days 6 - 90	Emergency Room Copay: \$75
Out of Pocket Max: \$3,450	Specialist Visit Copay: \$0		Ambulance Copay: \$250

014 MediMax (HMO) - Palm Beach

Monthly Premium: \$27.90	Primary Care Visit Copay: \$0	Inpatient Hospital Copay: \$0	Emergency Room Copay: \$0
Out of Pocket Max: \$3,450	Specialist Visit Copay: \$0		Ambulance Copay: \$0

015 MediSun Plus (HMO) - Miami-Dade & Broward

Monthly Premium: \$29.50	Primary Care Visit Copay: \$0	Inpatient Hospital Copay: \$0	Emergency Room Copay: \$0
Out of Pocket Max: \$3,450	Specialist Visit Copay: \$0		Ambulance Copay: \$0

016 MediSun Plus (HMO) - Palm Beach

Monthly Premium: \$26.20	Primary Care Visit Copay: \$0	Inpatient Hospital Copay: \$0	Emergency Room Copay: \$0
Out of Pocket Max: \$3,450	Specialist Visit Copay: \$0		Ambulance Copay: \$0

Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail each month or yearly. You can also choose to pay your premium and/or late enrollment penalty by automatic deduction from your Social Security or Railroad Retirement Board 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 Railroad Retirement Board. **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 won't have a coverage gap or a late enrollment penalty. Many people qualify 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 for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Payment Method

Please select a premium payment option. If you don't select a payment option, you will get a yearly bill.

- Get a bill
- Automatic deduction from your monthly Social Security or RRB benefit check:
I get monthly benefits from: Social Security RRB

(The Social Security 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.)

Typically, you may enroll in a Medicare Advantage plan only 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. By checking any of the following 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 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 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 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. **From October 1 through March 31**, we are open seven days a week from 8 a.m. to 8 p.m. (we close on Thanksgiving and Christmas Day). **From April 1 through September 30**, we are open Monday through Friday from 8 a.m. to 8 p.m. (we close federal holidays). **TTY users should call (877) 206-0500.**

Applicant Signature

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: _____

Address: _____

City: _____ State: ____ Zip-Code: _____ - _____

Phone Number: (____) _____ - _____

Relationship to Enrollee: _____

Submission Options

Mail form to:

Membership Department
HealthSun Health Plans
9250 W Flagler Street Suite 400
Miami, FL 33174-3460

Fax form to:

305-234-9275

Scan and e-mail form to:

sales@healthsun.com

Office Use Only:

Agent Signature: _____ Agent Print Name: _____

Plan Writing ID: _____ Phone Number: (____) _____ - _____