HealthSun

HEALTH PLANS

2022 Enrollment Request Form

HealthSun Health Plans is an HMO plan with a Medicare contract and a Medicaid contract with the State of Florida Agency for Health Care Administration. 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_2022ENRAP_C CMS Approved 8/30/2021

OMB No. 0938-1378
Expires: 7/31/2023

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

Proposed Effective Date: _____

Select the HealthSun plan you want to join in the Florida county where you reside		
Miami-Dade	☐ 001 HealthAdvantage (HMO)	$0 per month
	☐ 017 HealthAdvantage Plus (HMO)	$0 per month,
	☐ 019 MediSun Extra (HMO D-SNP)	$34.30 per month
	☐ 015 MediSun Plus (HMO D-SNP)	$34.30 per month
	☐ 006 MediMax (HMO)	$34.30 per month
Broward	☐ 012 HealthAdvantage (HMO)	$0 per month
	☐ 018 HealthAdvantage Plus (HMO)	$0 per month
	☐ 019 MediSun Extra (HMO D-SNP)	$34.30 per month
	☐ 015 MediSun Plus (HMO D-SNP)	$34.30 per month
	☐ 006 MediMax (HMO)	$34.30 per month
Palm Beach	☐ 013 HealthAdvantage (HMO)	$0 per month
	☐ 016 MediSun Plus (HMO D-SNP)	$34.30 per month

Last Name:	**First Name:**	**MI:**

Birth date (MM/DD/YYYY):	**Sex:**	**Home Phone Number:**	**Alternate Phone Number:**
___ ___ / ___ ___ / _____	☐ M ☐ F	(____) _____ - _____	(_____) _____ - _____

Permanent Residence Street Address (Don't enter a PO Box):

City:	**County:**	**State:**	**Zip:**

Mailing Address, if different from your address (PO Box allowed):

City:	**County:**	**State:**	**Zip:**

Emergency Contact Information

Contact Name:	**Relationship to you:**	**Phone Number:**
		(_____) _____ - _____

Please Provide Your Medicare Insurance Information

Medicare Number (MBI):

_____ _____ _____ _____ – _____ _____ _____ – _____ _____ _____ _____

Answer these important questions:

1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to HealthSun? ☐ **Yes** ☐ **No**
Name of other coverage: **Member Number of coverage:** **Group number of coverage:**

2. Are you enrolled in your State Medicaid Program? ☐ **Yes** ☐ **No**
Please provide your Medicaid number: _____

List your Primary Care Physician (PCP)

PCP ID:	**PCP Name:**	**Medical Center** (if applicable)**:**

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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. 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 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 returned to the U.S. on (insert date) _____ after living permanently outside of the U.S.
- ☐ 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. From April 1st to September 30th, we are open Monday through Friday 8am to 8pm (we close on federal holidays). From October 1st to March 31st, we are available seven days a week from 8am to 8pm (we close Thanksgiving and Christmas Day).

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in a language other than English:

☐ **Spanish** ☐ **Other:** _____

Select one if you want us to send you information in an accessible format:

☐ **Braille** ☐ **Large Print** ☐ **Audio CD**

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. Our office hours **from April 1st through September 30th** are Monday through Friday from 8am to 8pm (we close federal holidays). **From October 1st until March 31st,** we are open seven days a week from 8am to 8pm (we close Christmas Day and Thanksgiving Day). **TTY users should call 1-877-206-0500.**

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

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, each month or in one annual payment. **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 the 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 HealthSun Health Plans the Part D-IRMAA.

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

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. For more information about this Extra Help, contact your local Social Security office 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.

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IMPORTANT: Please Read and Sign Below

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

Signature:	**Today's Date:**

If you're the authorized representative, sign above and fill out these fields:

If you have only witnessed the enrollment request, do <u>not</u> sign above and only complete below.

Name: _____ Phone Number: _____

Address: _____ Relationship to Enrollee: _____

Office Use Only

Agent/Broker, complete with your information:

Print Name: _____ Writing ID: _____

Signature: _____ Phone Number: _____

Application Receipt Date: _____

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.

Who can use this form?
People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug 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 January1)
- 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 on page 1. The items on page 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 monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?
Send your completed and signed form to:
HealthSun Health Plans
Attn: Membership
Department
9250 West Flagler Street
Suite 600
Miami, FL 33174

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

How do I get help with this form?
Call HealthSun Health Plans at 1-877-336-2069. TTY users can call 1-877-206-0500.

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

En español: Llame a HealthSun Health Plans al 1-877-336-2069/TTY 1-877-206-0500 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0939-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.