HealthSun
HEALTH PLANS

2023 Enrollment Form

Complete this form to join HealthSun Health Plans

Have your Medicare card ready

If you don't have your Medicare card we might be able to lookup your MBI # with

- Full Name
- Date of Birth
- Social Security Number

Sign and Date your Enrollment Form

If the form is not filled completely your enrollment in our plan may be denied.

Electronic Enrollment

You can enroll online with our quick and easy enrollment mechanism:

Visit: healthsun.com/how-to-enroll

See: Option 2: Enroll Online

Complete an electronic enrollment request

Click: START ENROLLING ONLINE

Speak to a Licensed Agent

If you have questions about our benefits or would like more information about our plans before making a decision reach out to one of our licensed agents.

Call HealthSun Health Plans at 1-877-336-2069. TTY users can call 1-877-206-0500. 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.**

What Happens next?

Send your completed and signed form to:

HealthSun Health Plans
Attention: Membership
9250 West Flagler Street
Suite 600
Miami, FL 33174

2023 HealthSun Enrollment Form

Please print information clearly and exactly as it appears on your Medicare card.

Sales-assisted application, please complete:

Sales Agent HealthSun ID: _____

Proposed Effective Date: _____

Application Received Date: _____

SECTION 1 - All fields on this page are required (unless marked optional)		
Last Name:	**Date of Birth (MM/DD/YYYY):** ___ ___ / ___ ___ / ___ ___ ___ ___	
First Name:	**MI** (Optional):	**Sex** ☐ **M** ☐ **F**
Permanent Residence Address (Don't enter a PO Box):		
City:	**State: FL**	**Zip Code:**
County (Optional): ☐ **Miami-Dade** ☐ **Broward** ☐ **Palm Beach**		
Mailing Address, if different from your permanent address (PO Box allowed):		
City:	**State:**	**Zip Code:**
Primary Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	**Alternate Phone Number:** (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	

Your Medicare information

Medicare Number:

_____ _____ _____ _____ ___ _____ _____ _____ ___ _____ _____ _____ _____

Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to HealthSun?

☐ **Yes** ☐ **No**

Name of other coverage _____

Member Number for this coverage _____

Group number _____

Are you enrolled in your State Medicaid Program?

☐ **Yes** ☐ **No**

Please provide your Medicaid number: _____

Emergency Contact Information (optional)

Emergency Contact Name	
Emergency Contact Relationship	**Emergency Contact Phone Number** (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

SECTION 1 (cont'd) - All fields on this page are required (unless marked optional)	
Select the HealthSun Plan you want to join.	
☐ **HealthSun HealthAdvantage (HMO)** H5431-001 Miami-Dade County	**$0 per month**
☐ **HealthSun HealthAdvantage (HMO)** H5431-012 Broward County	**$0 per month**
☐ **HealthSun HealthAdvantage (HMO)** H5431-013 Palm Beach County	**$0 per month**
☐ **HealthSun HealthAdvantage Plus (HMO)** H5431-017 Miami-Dade County	**$0 per month**
☐ **HealthSun HealthAdvantage Plus (HMO)** H5431-018 Broward County	**$0 per month**
☐ **HealthSun HealthAdvantage Plus (HMO)** H5431-020 Palm Beach County	**$0 per month**
☐ **HealthSun MediMax (HMO)** H5431-006 Miami-Dade County and Broward County	**$35.90 per month**
☐ **HealthSun MediSun Extra (HMO D-SNP)** H5431-019 Miami-Dade County and Broward County *Must be enrolled in Medicaid through the State of Florida to enroll in this plan.*	**$35.90 per month**
☐ **HealthSun MediSun Plus (HMO D-SNP)** H5431-016 Palm Beach County *Must be enrolled in Medicaid through the State of Florida to enroll in this plan.*	**$35.90 per month**

SECTION 1 (cont'd) - All fields on this page are required (unless marked optional)

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, 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.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- 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.
- 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 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:** _____

Relationship to Enrollee: _____ **Address:** _____

SECTION 2 – All fields on this page are optional

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

List your Primary Care Physician (PCP) selected with HealthSun Health Plans:

PCP ID:	**PCP Name:**	**Medical Center/Clinic Name:**

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

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ Yes, Cuban
☐ Yes, Puerto Rican
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, other Hispanic, Latino/a, Spanish origin
☐ No, not Hispanic, Latino/a, Spanish origin
☐ **I choose not to answer**

What's your race? Select all that apply.

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Chinese
☐ Japanese
☐ Vietnamese
☐ Korean
☐ Asian Indian
☐ Filipino
☐ Other Asian
☐ Native Hawaiian
☐ Samoan
☐ Guamanian or Chamorro
☐ Other Pacific Islander
☐ **I choose not to answer**

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 other than what is listed above. Our office hours are 8am to 8pm. From April 1st through September 30th we are available Monday through Friday (closed on federal holidays). From October 1st until March 31st, we are open seven days a week (closed on Christmas Day and Thanksgiving Day). TTY users should call 1-877-206-0500.

I want to get the following materials via email. Select one or more.

☐ 2023 Provider and Pharmacy Directory ☐ 2023 Drug Formulary ☐ 2023 OTC Catalog

☐ 2023 Summary of Benefits for Plan # _____ ☐ 2023 Evidence of Coverage for Plan # _____

Email address: _____

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. 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 annually

☐ Automatic deduction from your monthly Social Security or RRB benefit check

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 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 planof 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.

SECTION 3 - ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

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.
- ☐ I am enrolling in a 5-star plan rated by Medicare.
- ☐ Other: _____

If none of these statements applies to you or you are 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).

SECTION 4 - OFFICE USE ONLY

Agent/Broker: Please complete all fields below.

Applicant Election Type: ☐ AEP ☐ OEP ☐ IEP/ICEP ☐ SEP

Scope of Appointment (SOA) Type: ☐ Face-to-face ☐ Telephone ☐ Webcam

How was the SOA collected?

☐ Paper Form

☐ Electronic Form

☐ Recorded Call (voice recording ID): _____
ACCESS CODE + LAST 4 DIGITS OF PHONE NUMBER USED TO RECORD CALL

Agent Print Name: _____ _____
FIRST NAME LAST NAME

Writing Agent Plan ID: ___ ___ ___ ___ ___ ___ **Phone Number:** (_____) _____ - _____

Writing Agent TIN Code (if applicable)**:** ___ ___ ___ ___ ___ ___ ___ ___ ___

Signature: _____ **Application Receipt Date:** _____

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. 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).

Important Information

OMB No. 0938-1378
Expires: 7/31/2024

Who can use this form?

People with Medicare who want to join a Medicare Advantage 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 in Section 1. The items in Section 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
Attention: Member Services
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 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.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

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 0938-1378) 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.