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

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

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 January 1)
- 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.

Reminders:
- 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 bank account or your monthly Social Security (or Railroad Retirement Board) Benefit.

What happens next?
Send your completed and signed form to:
HealthSun Health Plans
9250 W. Flagler Street Suite 600
Miami, FL 33174
Or **fax** to: 786-363-8115

You can also enroll **online** at:
www.healthsun.com

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/ 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.

HealthSun Health Plans

Individual Enrollment Request Form-2024

Section 1-All fields below are required (unless marked optional). Please check the plan you want to enroll in.	
☐ **HealthSun HealthAdvantage (HMO)**	**$0 per month**
Available in these counties: Broward, Miami-Dade, Palm Beach	
☐ **HealthSun HealthAdvantage Plus (HMO)**	**$0 per month**
Available in these counties: Broward, Miami-Dade, Palm Beach	
☐ **HealthSun MediMax (HMO)**	**$23.90 per month**
Available in these counties: Broward, Miami-Dade	
☐ **HealthSun MediSun Extra (HMO D-SNP)**	**$19.80 per month**
Available in these counties: Broward, Miami-Dade *Must be enrolled in Medicaid through the State of Florida to enroll in this plan.*	
☐ **HealthSun MediSun Plus (HMO D-SNP)**	**$10.90 per month**
Available in this county: Palm Beach *Must be enrolled in Medicaid through the State of Florida to enroll in this plan.*	
☐ **HealthSun VitalCare (HMO C-SNP)**	**$0 per month**
Available in these counties: Broward, Miami-Dade, Palm Beach	

Last name	**First name**	**MI**

Birthdate (MM/DD/YYYY)	**Sex** ☐M ☐F	**Email** (Optional) @

Phone number	**Alternate phone number**

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

☐ Provider and Pharmacy Directory ☐ Drug Formulary ☐ OTC Catalog

☐ Summary of Benefits for Plan # _____

☐ Evidence of Coverage for Plan # _____

Permanent residence street address (Don't enter a P.O. Box)

City	State	ZIP code	County

Mailing address (only if different from your permanent address; P.O. Box allowed)

City	State	ZIP code

Applicant Complete: Name _____ and Medicare Number _____

Your Medicare information
Medicare Number: ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___ Please locate the 11-digit alpha-numeric number on your Medicare Card. **Example**: 1EG4-TE5-MK72 Effective Date: HOSPITAL (Part A) _____ MEDICAL (Part B) _____

Answer these important questions:				
Will you have other prescription drug coverage (like VA, TRICARE) in addition to HealthSun Health Plans? ☐Yes ☐No				
Name of other coverage:	Member number for this coverage:	Group number for this coverage:	Start Date: (MM/DD/YYYY)	End Date: (MM/DD/YYYY)
Are you enrolled in your State Medicaid program? ☐Yes ☐No If "yes," please provide your Medicaid number: _____				
Please choose the name of a primary care physician (PCP). If you do not choose a PCP, we will select a high quality rated provider for you. **PCP ID #** (as shown in the printed or online Provider Directory) _____ PCP name _____ (First Name) _____ (Last Name) Primary Medical Group (PMG) name _____ PCP address _____ City _____ State _____ ZIP code _____ **Are you now seeing or have you recently seen this doctor?** ☐Yes ☐No				

Emergency Contact Information (Optional)	
Emergency Contact Name	
Emergency Contact Relationship	**Emergency Contact Phone Number**

Enrollment form

Applicant Complete: Name _____

Section 2 - All fields in this section are optional
Answering these questions is your choice. **You can't be denied coverage because you don't fill them out.**

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

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

What's your race? Select all that apply.

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

Please check one of the boxes below if you would prefer us to send you information in another language or in an accessible format:

☐ Spanish

☐ Voice-Enabled (Audio) PDF ☐ Large Print

Please contact HealthSun at **1-877-336-2069** if you need information in an accessible format or language other than what's listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. TTY users can 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 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 this 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.**

Applicant Complete: Name _____

Special Supplemental Benefits for the Chronically Ill (SSBCI)

(benefits vary by plans)

HealthSun VitalCare (HMO C-SNP) plans include special supplemental benefits for the chronically ill.

HealthSun MediMax (HMO), HealthSun HealthAdvantage Plan (HMO), HealthSun HealthAdvantage Plus (HMO), HealthSun MediSun Plus (HMO D-SNP), and HealthSun MediSun Extra (HMO D-SNP) plans include special supplemental benefits for the chronically ill, not all members in these plans will qualify. Please see the last page of this application for a list of qualifying conditions.

Refer to your plan's *Evidence of Coverage* to find what your plan offers if you are eligible to receive special supplemental benefits for the chronically ill.

☐ I acknowledge that my plan offers benefits with allowances. (Please refer to the Plan EOC for details.) My plan may contact my provider if they need more information. I understand unused benefits do not rollover.

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Typically, you may enroll in a Medicare Advantage (MA) plan only during the Annual Enrollment Period (AEP) between October 15 and December 7 of each year or during the Open Enrollment Period (OEP) between January 1 to March 31. Beneficiaries enrolled in a MA-PD plan may use the OEP to switch to another MA-PD plan; a MA-only plan; or Original Medicare with/without a PDP. Additionally, there are exceptions - i.e., Initial Enrollment Period (IEP/ICEP) and Special Enrollment Periods (SEPs) — that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements carefully and check all of the boxes where there is a statement that applies to you. By checking any of the following boxes 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.

NOTE: At least one option below needs to be selected.

- ☐ I am enrolling during the Annual Open Enrollment Period from October 15 to December 7. (AEP)
- ☐ I am new to Medicare. (IEP/ICEP)
- ☐ I am turning 65 and not new to Medicare. (IEP2)
- ☐ I have a qualifying condition. (SEP)
- ☐ I recently moved outside my service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____. (SEP)
- ☐ 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. (SEP)
- ☐ 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) _____. (SEP)

Applicant Complete: Name _____

- ☐ 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 disaster. (SEP)
- ☐ I recently had a change in my Medicaid/Extra Help paying for my Medicare prescription drug coverage (newly got Medicaid/Extra Help, had a change in the level of Medicaid/Extra Help, or lost Medicaid/Extra Help) on (insert date) _____. (SEP)
- ☐ 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/will move into/out of the facility on (insert date) _____. (SEP)
- ☐ I recently left a Program of All-inclusive Care for the Elderly (PACE®) program on (insert date) _____. (SEP)
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____. (SEP)
- ☐ I am leaving employer or union coverage. Employer/Union coverage started on (insert date) _____ and coverage ends on (insert date) _____. (SEP)
- ☐ I belong to a pharmacy assistance program provided by my state. (SEP)
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____. (SEP)
- ☐ My plan is ending its contract with Medicare or Medicare is ending its contract with my plan. (SEP)
- ☐ 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) _____. (SEP)
- ☐ I was recently released from incarceration. I was released on (insert date) _____. (SEP)
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____. (SEP)
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period. (MA OEP)
- ☐ I am enrolling in a 5-star plan rated by Medicare.
- ☐ Other* _____

*If none of these statements apply to you or you're not sure, please contact HealthSun Health Plans at **1-877-336-2069** (TTY users should call **1-877-206-0500**) to see if you are eligible to enroll. Our office hours are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

Applicant Complete: Name _____

Section 3 - 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, I acknowledge that HealthSun 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 coverage begins, I must get all of my medical and prescription drug benefits from HealthSun. Benefits and services provided by HealthSun 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 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 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.

Signature Required to process your application.

Applicant signature **X**	**Today's date**
Desired plan effective date*:	

*Subject to Medicare election period guidelines

Authorized Representative Information Only		
All fields within this section must be completed if the application has been signed by an Authorized Representative and not the Applicant.		
Name		
First Name	Last Name	
Address		
City	**State**	**ZIP code**
Phone Number	**Relationship to Enrollee**	
☐ **I have submitted Authorized Representative documentation with this application.**		

Applicant Complete: Name _____

Applicant: Please do not complete the following sections.
Agent/Broker: Please fill in ALL fields including 'Writing Agent' and 'Agency' with your assigned Encrypted ID, Code, or Tax ID based on your appointed brand, state AND product.

☐ IEP/ICEP ☐ AEP ☐ OEP ☐ SEP (type): _____ ☐ Not eligible

I helped the applicant fill out this application. ☐ Yes ☐ No

Scope of Appointment (SOA)

Appointment type: ☐ Face-to-face ☐ Telephone ☐ Webcam

How was the scope of appointment (SOA) collected?

☐ Paper ☐ Electronic ☐ Recorded call (voice recording ID) _____

Print name _____ _____
First Name Last Name

Writing Agent TIN Code (if applicable) __ __ __ __ __ __

Agency Name _____

Phone _____

Email @ _____

Signature _____ Application received date _____

Translation services are available; please contact the plan or your agent.

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. Section 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 plan.

Applicant Complete: Name _____

This information will only be used for the purposes of Special Supplemental Benefits for the Chronically Ill (SSBCI) and will not impact your enrollment in the plan.

*By selecting this benefit, I attest that I have been diagnosed with and treated for one of the following conditions:

☐ Alzheimer's	☐ Amyotrophic lateral sclerosis (ALS)	☐ Ankylosing spondylitis	☐ Aplastic anemia
☐ Asthma	☐ Bipolar disorders	☐ Blindness	☐ Cancer (excluding pre-cancer conditions or in-situ status)
☐ Cardia arrhythmias	☐ Cerebral Palsy	☐ Chronic alcohol dependence	☐ Chronic back pain
☐ Chronic bronchitis	☐ Chronic drug dependence	☐ Chronic heart failure	☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Chronic venous thromboembolic disorder	☐ Coronary artery disease	☐ Crohn's disease	☐ Cystic Fibrosis
☐ Dementia	☐ Diabetes mellitus	☐ Emphysema	☐ End-stage liver disease
☐ End-stage renal disease (ESRD) requiring dialysis	☐ Epilepsy	☐ Hemophilia	☐ HIV/AIDS
☐ Huntington's disease	☐ Hypertension	☐ Immune thrombocytopenic purpura	☐ Ischemic heart disease
☐ Major depressive disorders	☐ Multiple sclerosis	☐ Myelodysplastic syndrome	☐ Obesity (BMI is greater than or equal to 30)
☐ Osteoarthritis	☐ Osteoporosis	☐ Paralysis**	☐ Paranoid disorder
☐ Parkinson's disease	☐ Peripheral vascular disease	☐ Polyarthritis nodosa	☐ Polymyalgia rheumatic
☐ Polymyositis	☐ Polyneuropathy	☐ Pre-diabetes***	☐ Pulmonary fibrosis
☐ Pulmonary hypertension	☐ Rheumatoid arthritis	☐ Schizoaffective disorder	☐ Schizophrenia
☐ Scleroderma	☐ Sickle-cell disease (excluding sickle-cell trait)	☐ Spinal stenosis	☐ Stroke
☐ Stroke-related neurologic deficit	☐ Systemic lupus erythematosus	☐ Traumatic brain injury	

**Paralysis: i.e., hemiplegia, quadriplegia, paraplegia, monoplegia

***Pre-diabetes: (Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%)

Applicant Complete: Name _____