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 2024 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.

Y0114_2024CNGPBP_C CMS Approved 10/03/2023

2024 Plan Change Form
Switch from Plan to Plan within HealthSun Health Plans

Your Information			
Member Name:			
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:**
Member ID (ex. HSXXXXXX-XX)**:**			
Medicare Number (MBI): _____ _____ _____ – _____ _____ _____ – _____ _____ _____ _____			
Are you enrolled in your State Medicaid Program? ☐ **Yes** ☐ **No** **Please provide your Medicaid number:** _____			

Communication Preferences

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:

☐ Spanish ☐ Other Language: _____

☐ 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. **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 are close on federal holidays). **TTY users should call 1-877-206-0500.**

Plan Selection

I am currently a member of HealthSun _____
HealthSun Plan Name and/or number

with a monthly premium of $_____.

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. This information is not a complete description of benefits. Call 1-877-336-2069 for more information. **Please check the appropriate box below *(check one)*:**

☐ **001 HealthAdvantage Plan (HMO) Miami-Dade**

Monthly Premium: $0 Out of Pocket Max: $1,500	Primary Care Physician: $0.00 copay Specialist Physician: $0.00 copay	Inpatient Hospital: $0.00 copay	Emergency Room: $50.00 copay Ground Ambulance: $75.00 copay

☐ **012 HealthAdvantage Plan (HMO) Broward**

Monthly Premium: $0 Out of Pocket Max: $2,500	Primary Care Physician: $0.00 copay Specialist Physician: $0.00 copay	Inpatient Hospital: $0.00 copay	Emergency Room: $90.00 copay Ground Ambulance: $200.00 copay

☐ **013 HealthAdvantage Plan (HMO) Palm Beach**

Monthly Premium: $0 Out of Pocket Max: $3,450	Primary Care Physician: $0.00 copay Specialist Physician: $0.00 copay	Inpatient Hospital: Days 1-6: $20.00 copay, per day. Days 7-90: $0.00 copay	Emergency Room: $90.00 copay Ground Ambulance: $250.00 copay

☐ **017 HealthAdvantage Plus (HMO) Miami-Dade**

Monthly Premium: $0 Out of Pocket Max: $3,450 Part B Premium Reduction: $164.90	Primary Care Physician: $0.00 copay Specialist Physician: $0.00 copay	Inpatient Hospital: $0.00 copay	Emergency Room: $120.00 copay Ground Ambulance: $150.00 copay

☐ **018 HealthAdvantage Plus (HMO) Broward**

Monthly Premium: $0 Out of Pocket Max: $3,450 Part B Premium Reduction: $164.90	Primary Care Physician: $0.00 copay Specialist Physician: $0.00 - $15.00 copay	Inpatient Hospital: Days 1-5: $150.00 copay, per day. Days 6-90: $0.00 copay	Emergency Room: $120.00 copay Ground Ambulance: $250.00 copay

☐ **020 HealthAdvantage Plus (HMO) Palm Beach**

Monthly Premium: $0 Out of Pocket Max: $3,450 Part B Premium Reduction: $164.90	Primary Care Physician: $0.00 copay Specialist Physician: $0.00 - $15.00 copay	Inpatient Hospital: Days 1-5: $150.00 copay, per day. Days 6-90: $0.00 copay	Emergency Room: $120.00 copay Ground Ambulance: $250.00 copay

☐ **006 MediMax (HMO) Miami-Dade & Broward**

Monthly Premium: $23.90	Primary Care Physician:	Inpatient Hospital:	Emergency Room:
Out of Pocket Max: $3,450	$0.00 copay	$0.00 copay	$0.00 copay
	Specialist Physician:		Ground Ambulance:
	$0.00 copay		$0.00 copay

☐ **019 MediSun Extra (HMO D-SNP) Miami-Dade & Broward**

Monthly Premium: $19.80	Primary Care Physician:	Inpatient Hospital:	Emergency Room:
Out of Pocket Max: $3,450	$0.00 copay	$0.00 copay	$0.00 copay
	Specialist Physician:		Ground Ambulance:
	$0.00 copay		$0.00 copay

☐ **016 MediSun Plus (HMO D-SNP) Palm Beach**

Monthly Premium: $10.90	Primary Care Physician:	Inpatient Hospital:	Emergency Room:
Out of Pocket Max: $3,450	$0.00 copay	$0.00 copay	$0.00 copay
	Specialist Physician:		Ground Ambulance:
	$0.00 copay		$0.00 copay

☐ **021 VitalCare (HMO C-SNP) Miami-Dade & Broward**

Monthly Premium: $0	Primary Care Physician:	Inpatient Hospital:	Emergency Room:
Out of Pocket Max: $1,900	$0.00 copay	$0.00 copay	$90.00 copay
Part B Premium Reduction:	Specialist Physician:		Ground Ambulance:
$164.90	$0.00 copay		$150.00 copay

☐ **022 VitalCare (HMO C-SNP) Palm Beach**

Monthly Premium: $0	Primary Care Physician:	Inpatient Hospital:	Emergency Room:
Out of Pocket Max: $2,450	$0.00 copay	Days 1-5: $150.00 copay,	$90.00 copay
Part B Premium Reduction:	Specialist Physician:	per day.	Ground Ambulance:
$164.90	$0.00 - $15.00 copay	Days 6-90: $0.00 copay	$250.00 copay

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 yearly. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month.

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 help pay for 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 https://www.ssa.gov/medicare/part-d-extra-help.

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

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

Please select a premium payment option:

☐ 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.)

The 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, Cuban
- ☐ Yes, Puerto Rican
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ 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:
  - ☐ Asian Indian
  - ☐ Chinese
  - ☐ Filipino
  - ☐ Japanese
  - ☐ Korean
  - ☐ Vietnamese
  - ☐ Other Asian
- ☐ Black or African American
- ☐ Native Hawaiian and Pacific Islander:
  - ☐ Guamanian or Chamorro
  - ☐ Native Hawaiian
  - ☐ Samoan
  - ☐ Other Pacific Islander
- ☐ White
- ☐ **I choose not to answer.**

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 have a qualifying condition.
- ☐ 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 October 1st to March 31st**, we are available seven days a week from 8am to 8pm (we close Thanksgiving and Christmas Day). **From April 1st to September 30th**, we are open Monday through Friday 8am to 8pm (we close on federal holidays).

Please Read and Sign Below

HealthSun Health Plans is a plan that has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with HealthSun Health Plans, he/she may be paid based on my enrollment in HealthSun Health Plans.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that HealthSun Health Plans 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 people with Medicare aren't 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 Health Plans coverage begins, I must get all of my health care from HealthSun Health Plans, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by HealthSun Health Plans and other services contained in my HealthSun Health Plans Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR HEALTHSUN HEALTH PLANS WILL PAY FOR THE SERVICES.

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 from Medicare.

Applicant Signature

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 not sign above and only complete below)***:**

Name: _____ Phone Number: _____

Address: _____ Relationship to Enrollee:_____

Submission Options

Mail form to:
Membership Department
HealthSun Health Plans
9250 W Flagler Street Suite 600
Miami, FL 33174

Fax form to:
786-363-8115

Scan and e-mail form to:
sales@healthsun.com

Office Use Only

Agent/Broker, complete with your information:

Agent Print Name: _____ Plan Writing ID: _____

Agent Signature: _____ Phone Number: _____

Application Receipt Date: _____