SecurityHealth Plan℠
Promises kept, plain and simple.®

Ally Rx Dual-eligible Special Needs Plan

2019 Enrollment Request

FOR OFFICE USE ONLY		
Member ID no.	Effective date	Election period individual is enrolling in: ☐ AEP ☐ SEP ☐ ICEP ☐ IEP ☐ OEPI

FOR STAFF/AGENT/BROKER USE ONLY		
Email: medicareadvantage.agent@securityhealth.org Fax: 715-221-9607		
Name of staff member/agent/broker (if assisted in enrollment)	Agent no.	First received date
Check one: ☐ Seminar attendee ☐ Walk-in ☐ Phone consult ☐ Scheduled appointment		

Please contact Security Health Plan if you need information in another language or format (Braille).

To enroll in Ally Rx (HMO SNP) with $0 premium, please provide the following information. (NOTE: To be elibigle to enroll in Ally Rx you must currently be eligible for full benefit Medicaid.)

LAST name	FIRST name	Middle initial
☐ Mr. ☐ Mrs. ☐ Ms.	Birthdate (mm/dd/yyyy) ___ ___ /___ ___ / ___ ___ ___ ___	Sex: ☐ Male ☐ Female
Home phone number (_____) ___ ___ ___ – ___ ___ ___ ___	Alternate phone number (_____) ___ ___ ___ – ___ ___ ___ ___	
Permanent residence street address (P.O. box is not allowed)		
City	County	State / ZIP Code
Mailing address (only if different from permanent residence address)		
Street address	City	State / ZIP code
Email address (optional)		
Emergency contact name (optional)	Relationship to you	Phone number

Please continue to page 2

Please provide your Medicare insurance information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

OR

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board

Name (as it appears on your Medicare card)

_____

Medicare number _____

Is entitled to:	Effective date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Attestation of eligibility for an enrollment period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through 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 the box if the statement 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.

- ☐ 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 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 was released from incarceration. I was released on (insert date) _____ /_____ /_____ .
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____ /_____ /_____ .
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____ /_____ /_____ .
- ☐ 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 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.

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Attestation of eligibility for an enrollment period (continued)

- ☐ 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) _____ /_____ /_____ .
- ☐ I recently left a PACE program on (insert date) _____ /_____ /_____ .
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____ /_____ /_____ .
- ☐ I am leaving employer or union coverage on (insert date) _____ /_____ /_____ .
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ 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 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.

If none of these statements applies to you or you're not sure, please contact Security Health Plan at 1-877-998-0998 or 715-221-9897 (TTY users should call 711) to see if you are eligible to enroll. We are open 7 days a week, 8 a.m. to 8 p.m., from Oct. 1 – March 31; and Monday through Friday, 8 a.m. to 8 p.m., from April 1 – Sept. 30.

Please continue to page 4

Paying 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 or automatic premium deduction from your bank account, credit card or debit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75 percent or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible 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. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

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

Please select a premium payment option:

☐ Get a bill

☐ Automatic premium deduction each month from bank account (To choose this option, complete the Automatic Premium Deduction Plan brochure.)

☐ Automatic premium deduction each month by credit or debit card (After your enrollment has been processed, a Security Health Plan representative will contact you to assist in setting up your credit or debit card payments.)

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check
I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB 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.)

Please continue to page 5

Please read and answer these important questions

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.

   Will you have other prescription drug coverage in addition to your Medicare Advantage plan: ☐ Yes ☐ No

   If yes, please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage _____ ID # for this coverage _____ Group # for this coverage _____

2. Are you a resident in a long-term care facility such as a nursing home: ☐ Yes ☐ No

   If yes, please provide the following information:

   Name of institution _____

   Address and phone number of institution (number and street)

   _____

3. Do you have end-stage renal disease (ESRD): ☐ Yes ☐ No

   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis. Otherwise we may need to contact you to obtain additional information.

4. Are you enrolled in your state Medicaid program: ☐ Yes ☐ No

   If yes, please provide your Medicaid number _____

5. Do you or your spouse work: ☐ Yes ☐ No

6. Please indicate the name of a Primary Care Physician (PCP), clinic or health center you have selected:

   Physician first name _____ Physician last name _____

   Clinic/health center _____

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:

☐ Large print

Please contact Security Health Plan at 1-877-998-0998 if you need information in an accessible format or language other than what is listed above. We are open 7 days a week, 8 a.m. to 8 p.m., from Oct. 1 – March 31; and Monday through Friday, 8 a.m. to 8 p.m., from April 1 – Sept. 30. TTY users should call 711.

STOP Please read this important information.

If you currently have health coverage from an employer or union, joining a Security Health Plan Medicare Advantage plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join a Security Health Plan Medicare Advantage plan. Read the communications your employer or union sends you. If you have questions, visit their website or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please continue to page 6

Please read and sign below

By completing this enrollment application, I agree to the following:

Security Health Plan is a Medicare Advantage plan and has a contract with the federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (example: Oct. 15 - Dec. 7 of every year), or under certain special circumstances.

Security Health Plan serves a specific service area. If I move out of the area that Security Health Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Security Health Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Security Health Plan when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Security Health Plan Medicare Advantage plan coverage begins, I must get all of my health care from Security Health Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Security Health Plan and other services contained in my Medicare Advantage plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR SECURITY HEALTH PLAN WILL PAY FOR THE SERVICES.**

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

Release of Information

By joining this Medicare health plan, I acknowledge that Security Health Plan of Wisconsin, Inc., will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Security Health Plan of Wisconsin, Inc., 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 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.

Signature	**Today's date**

If you are the authorized representative, you must sign above and provide the following information:

Name _____

Address _____

Phone number (_____) _____–_____

Relationship to enrollee: ☐ Power of Attorney Durable/Financial ☐ Guardian of Estate

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Discrimination is against the law

Security Health Plan of Wisconsin, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations. Security Health Plan does not exclude people or treat them differently because of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status.

Security Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at 1-877-998-0998 (TTY: 711). If you believe that Security Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status, you can file a grievance with:

Security Health Plan
Attn: Grievances
1515 North Saint Joseph Avenue
Marshfield, WI 54449-8000

Phone: 715-221-9596 (TTY: 711) Fax: 715-221-9424
Email: shp.appeals.grievance@securityhealth.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Security Health Plan can help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201

Phone: 1–800–368–1019 or 800–537–7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Language assistance services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-877-998-0998 (TTY: 711).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-998-0998 (TTY: 711).

Hmoob (Hmong)
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-998-0998 (TTY: 711).

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-998-0998 (TTY: 711)。

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Language assistance services (continued)

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-998-0998 (TTY: 711).

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-899-8990 (رقم هاتف الصم والبكم: 117).

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-998-0998 (телетайп: 711).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-998-0998 (TTY: 711) 번으로 전화해 주십시오.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-998-0998 (TTY: 711).

Deitsch (Pennsylvania Dutch)
Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: 1-877-998-0998 (TTY: 711).

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-998-0998 (TTY: 711).

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-998-0998 (ATS : 711).

Polski (Polish)
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-998-0998 (TTY: 711).

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-998-0998 (TTY: 711) पर कॉल करें।

Shqip (Albanian)
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-998-0998 (TTY: 711).

Tagalog (Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-998-0998 (TTY: 711).

Oroomiffa (Oromo/Somalia)
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-998-0998 (TTY: 711).

Large print – If you require materials in large print, please call 1-877-998-0998 (TTY: 711).

