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

MODEL INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C) OR MEDICARE PRESCRIPTION DRUG PLAN (PART D)

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 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.
- 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:

Security Health Plan
1515 N. St. Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

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

How do I get help with this form?

Call Security Health Plan at 1-877-998-0998. TTY users can call 711.

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

En español: Llame a Security Health Plan al 1-877-998-0998/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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.

SecurityHealth Plan[SM]

Promises kept, plain and simple.®

Ally Rx Dual-eligible Special Needs Plan

2022 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/Webinar attendee ☐ Walk-in ☐ Phone consult ☐ Scheduled appointment		

Section 1 - All fields on this page are required (unless marked optional)

To enroll in a Medicare Advantage plan, please provide the following information.

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 eligible to enroll in Ally Rx you must currently be eligible for full benefit Medicaid.)

Check box to add the optional supplemental dental benefit:

☐ Optional supplemental dental benefit **$34** per month

FIRST name	LAST name	Middle initial

☐ Mr. ☐ Mrs. ☐ Ms.	Birthdate (mm/dd/yyyy) ___ ___ /___ ___ / ___ ___ ___ ___	Sex: ☐ Male ☐ Female

Phone number (_______) ___ ___ ___ – ___ ___ ___ ___	Alternate phone number (_______) ___ ___ ___ – ___ ___ ___ ___

Permanent residence street address (Don't enter a PO Box)

City	County	State	ZIP Code

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

Street address	City	State	ZIP code

Email address (used to communicate Plan information)

Emergency contact name (optional)	Relationship to you	Phone number

Please continue to page 2

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Your Medicare Information

Medicare number ___ ___ ___ ___-___ ___ ___-___ ___ ___ ___

Hospital (Part A) effective date _____________ Medical (Part B) effective date _____________

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.
- ☐ 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) ______ /______ /______ .

Please continue to page 3

Attestation of eligibility for an enrollment period (continued)

☐ 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.

☐ I'm in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan.

☐ I'm in a plan that's had a star rating of less than 3 stars for the last 3 years. I want to join a plan with a star rating of 3 stars or higher.

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.

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 (like VA, TRICARE) 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	Member number for this coverage	Group number for this coverage
______________________________	______________________________	______________________________

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

   If yes, please provide your Medicaid number ____

Please continue to page 4

IMPORTANT: Read and sign below

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

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

Name ____________________

Address ____________________

Phone number (________) ________–________________

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

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.

Select one if you want us to send you information in a language other than English:
☐ Spanish ☐ Hmong ☐ Other ____________________

Select one if you want us to send you information in an accessible format: ☐ Braille ☐ Large print ☐ Audio CD

Please contact Security Health Plan at 1-877-998-0998 if you need information in an accessible format other than what's listed above. Our office hours are 7 days a week, 8 a.m. to 8p.m., Oct. 1-March 31; Monday through Friday, 8 a.m. to 8 p.m., April 1-Sept. 30. TTY users can call 711.

Do you work: ☐ Yes ☐ No Does your spouse work: ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center:

Physician first name ____________________

Physician last name ____________________

Clinic/health center ____________________

Please continue to page 5

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.

To pay your late enrollment penalty:

- ☐ 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

Notice of Nondiscrimination/Limited English Proficiency Language Services

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, religion, disability, age, sex, gender identity, sexual orientation or health status.

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).

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

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.