SecurityHealth Plan℠
Promises kept, plain and simple.®

Medicare Advantage HMO-POS Plans

2022 Short Enrollment Request

FOR OFFICE USE ONLY

Member ID no.	Effective date of coverage	Election period individual is enrolling in: ☐ AEP ☐ SEP ☐ ICEP ☐ IEP ☐ OEPI ☐ Not eligible

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

Name of plan you are enrolling in

Name	Subscriber number

Home phone number	Alternate 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)*

Street address	City	State	ZIP code

Email address (used to communicate Plan information)

I am **CURRENTLY** a member of the Medicare Advantage Plan in Security Health Plan with a monthly premium of:

Plans WITH prescription drug coverage

- ☐ Spirit Rx (HMO-POS) **$226** per month
- ☐ Essence Rx (HMO-POS) **$85** per month
- ☐ Assurance Rx (HMO-POS) **$0** per month
- ☐ Esteem Rx (HMO-POS) **$0** per month
- ☐ Surety Rx (HMO-POS) **$0** per month
- ☐ Promise Rx (HMO-POS) **$73** per month
- ☐ Ally Rx (HMO SNP) **$0** per month
- ☐ Ascend Rx (HMO-POS) **$40** per month

Plans WITHOUT prescription drug coverage

- ☐ Spirit (HMO-POS) **$150** per month
- ☐ Essence (HMO-POS) **$16** per month

I **WOULD LIKE TO CHANGE TO** the Medicare Advantage plan in Security Health Plan checked below. I understand that this plan has different health benefits and a monthly premium of:

Plans WITH prescription drug coverage

- ☐ Spirit Rx (HMO-POS) **$229** per month
- ☐ Ascend Rx (HMO-POS) **$40** per month
- ☐ Essence Rx (HMO-POS) **$88** per month
- ☐ Esteem Rx (HMO-POS) **$0** per month

Plans WITHOUT prescription drug coverage

- ☐ Spirit (HMO-POS) **$150** per month
- ☐ Essence (HMO-POS) **$18** per month

Check box to add the optional supplemental dental benefit:

- ☐ Optional supplemental dental benefit **$43** per month

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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) _____ /_____ /_____ .
- ☐ 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'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.

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Your plan premium

Esteem Rx plan: **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 pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit 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 RRB. Do NOT pay Security Health Plan the Part D-IRMAA.**

Ascend Rx, Essence, Essence Rx, Spirit, Spirit Rx plans: **You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) 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 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 Security Health Plan the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, 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 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 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 for this benefit. 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:

- ☐ Continue my existing payment method on file (No changes to my account or address information have occurred.)
- ☐ 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 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.)

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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:

☐ Braille ☐ Large print ☐ Audio CD ☐ Spanish ☐ Hmong ☐ Other _____

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.

Please read and sign below

Security Health Plan 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 Security Health Plan, he/she may be paid based on my enrollment in Security Health Plan.

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 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 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 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 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

Please continue to page 5

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, religion, 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).

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