network health

Network*Prime* (MSA)

Individual Enrollment Request Form

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

Section 1 – All fields on this page are required

I would like to enroll in:

☐ Network*Prime* (MSA) **$0** per month

Plan Effective Date
I would like my coverage to begin on:
_____/____/_____
(MM / DD / YYYY)

LAST Name: **FIRST Name**: **Middle Initial:**

Birth Date: (____/____/_____) (MM / DD / YYYY)	**Sex**: ☐ Male ☐ Female	**Home Phone Number**:	**Alternate Phone Number**:

Permanent Residence Street Address (Don't enter a PO Box):

City:	**County**:	**State**:	**Zip Code**:

Mailing Address (only if different from your Permanent Residence Address, PO Box allowed):

Street Address: _____ City: _____

State: _____ Zip Code: _____

Email Address:

Please Provide Your Medicare Insurance Information

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.

Please Answer This Important Question

1. To enroll in a Network Health Medicare Advantage Plan, you may not have other health coverage as described below. Please answer each of the following questions.
   A. Are you enrolled in your state Medicaid program? ☐ Yes ☐ No
   B. Are you receiving Medicare Hospice benefits? ☐ Yes ☐ No
   C. Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits or other health benefits that cover all or part of the annual Medicare MSA deductible. If you have any other such coverage, you aren't eligible to enroll in Network*Prime*.

If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage so we can decide if you are eligible to enroll in a Network Health Medicare Advantage Plan.

Name of Other Coverage: _____

ID # for This Coverage: _____

Group # for This Coverage: _____

2. Will you reside in the United States for at least 183 days during each year you are enrolled in Network*Prime*?

☐ Yes ☐ No

3. Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

Please check one of the boxes below if you would prefer us to send you information in an accessible format.

☐ Large print ☐ Braille ☐ Language other than English Language needed _____

Please contact Network Health Medicare Advantage Plan at 800-983-7587 (TTY 800-947-3529) if you need information in a language other than English. Our office hours are Monday–Friday, from 8 a.m. to 8 p.m.

IMPORTANT: Please read and sign on the next page

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

Network*Prime* 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. It is my responsibility to inform you of any health 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. I may leave this plan ("disenroll") during the Annual Enrollment Period that is October 15 through December 7 of every year (effective the following January 1) or under certain limited special circumstances, by sending a request in writing to Network Health Medicare Advantage Plan. If I choose a Medicare MSA plan and haven't before joined an MSA plan, then change my mind, I may cancel my enrollment by December 15 of the same year by contacting my plan to cancel my enrollment request. I understand that my enrollment into an MSA plan isn't complete until the bank account is established. I understand that I am enrolling in a plan that doesn't pay for Medicare covered services until a high deductible is met but allows me to use funds in my MSA account to pay for health services. Withdrawals made from the MSA bank account aren't taxed when used for IRS-qualified medical expenses. I would owe income tax and up to a 50 percent penalty for withdrawals used for non-medical expenses. After the deductible is met the plan pays 100 percent of Medicare-covered services.

If I have any questions regarding the initial set-up of my MSA bank account or any of the information in this enrollment form, I should contact Network Health at 800-983-7587 (TTY 800-947-3529).

Network Health Medicare Advantage Plan serves a specific service area. If I move out of the area that Network Health Medicare Advantage 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 Network Health Medicare Advantage 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 Network Health Medicare Advantage Plan when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.

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

I understand that if I disenroll before the end of the plan year (December 31), Network Health Medicare Advantage Plan may debit my MSA bank account for a prorated share of the current year's deposit to be returned to Medicare. The debit amount is based on the number of months left in the year after the disenrollment date. I understand that, if I die, my estate will be responsible for any money owed to Medicare. My estate keeps any amount over what is owed to Medicare.

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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 Network Health Medicare Advantage Plan will release my information 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. Please send the appropriate paperwork showing you are the authorized representative within two weeks of submitting the application.

Name: _____

Address: _____

Phone Number: (_____) _____

Relationship to Enrollee: _____

Keeping records – As an authorized representative, it is important that you keep records of when funds in the MSA account are used, as well as how funds are used.

Optional Supplemental Dental

☐ **YES,** I want to enroll in the Delta Dental of Wisconsin Supplemental Benefit. I understand that this is an optional benefit and that if I enroll by selecting "Yes", I will be billed an additional **$39** monthly premium by Network Health.

☐ **NO,** I do not want to enroll in this optional supplemental dental plan.

Office Use Only

Name of staff member/agent/broker (if assisted in enrollment): _____

Agent ID#: _____

Application left with prospect to mail: ☐ Yes ☐ No

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

BenefitWallet™

Master Signature Card — Medical Savings Account
The Bank of New York Mellon

Name (1): _____ Account Number: _____

SSN: _____ Date: _____

Name (2): _____ (Please print name of any additional "Authorized Signature" signed below.)

REQUEST FOR TAX CERTIFICATION

Under penalties for perjury, I certify that the SSN number shown on this form is my correct taxpayer identification number and I am a citizen or resident of the United States.

The IRS does not require you to consent to any provision of this document.

By signing this card and opening a Medical Savings Account with The Bank of New York Mellon (the "Bank"), I agree: (a) To be bound by the Deposit Agreement & Disclosure Statement applicable to the Medical Savings Account established by this card, as that agreement may be amended from time to time; (b) To be bound by the Bank's agreements and disclosures applicable to any additional accounts that I establish with the Bank in the future as an individual, custodian, or single trustee.

This Master Signature Card Agreement will remain in effect as long as I continuously maintain at least one covered account with the Bank.

Authorized Signature(s): Please sign your authorized signature(s) in the boxes below.

1. _____ 2. _____

In accordance with the US Patriot Act we are required to verify the identity all of our account holders. To do so most efficiently please provide a residential address if this kit was mailed to a P.O. Box:

Street Address: _____

City: _____ State: _____ Zip: _____

Beneficiary Designation Form

I hereby certify that, if I die before distribution has been completed, the value of my account shall be distributed to the person(s) named below. If all Primary Beneficiaries die before me, the Contingent Beneficiary(ies) named below will receive the value of my account

Primary Beneficiary(ies)			
Name		Name	
Address		Address	
City, State, and Zip		City, State, and Zip	
Relationship	SSN	Relationship	SSN
Date of Birth	Percent (%)	Date of Birth	Percent (%)
Contingent Beneficiary(ies)			
Name		Name	
Address		Address	
City, State, and Zip		City, State, and Zip	
Relationship	SSN	Relationship	SSN
Date of Birth	Percent (%)	Date of Birth	Percent (%)

Important:
Return the completed form to: BenefitWallet, P.O. Box 1584, Secaucus, NJ 07094-1584