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: _____

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.

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 These Important Questions

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.

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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

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Please provide the name and location of your personal doctor (also referred to as a primary care practitioner or PCP): _____

Select one if you want us to send you information in an alternate format or a language other than English.
☐ Large print ☐ Braille ☐ Audio CD ☐ Language other than English Language needed _____
Please contact Network Health Medicare Advantage Plan at 800-983-7587 if you need information in an accessible format other than what's listed above. Our office hours are Monday–Friday, from 8 a.m. to 8 p.m. TTY users can call 800-947-3529.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.
☐ No, not of Hispanic, Latino/a or Spanish origin ☐ Yes, Mexican, Mexican American, Chicano/a ☐ Yes, Cuban
☐ Yes, Puerto Rican ☐ 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 Indian ☐ Black or African American ☐ Chinese ☐ Filipino
☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander
☐ Samoan ☐ Vietnamese ☐ White ☐ **I choose not to answer**

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.

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.

Office Use Only

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

Agent ID#: _____

Date application was completed with agent/broker: _____

Application left with prospect to mail: ☐ Yes ☐ No

How was enrollment completed: ☐ Telephonic ☐ Virtual ☐ In-Person

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

PRIVACY ACT STATEMENT The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 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.

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

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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) _____.

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Attestation of Eligibility for an Enrollment Period

☐ 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 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.

If none of these statements apply to you or you're not sure, please contact Network Health Medicare Advantage Plans at 800-378-5234 (TTY 800-947-3529) to see if you are eligible to enroll. We are open Monday–Friday, from 8 a.m. to 8 p.m. From October 1 to March 31, we are available every day from 8 a.m. to 8 p.m.

Multi-Language Insert – REQUIRED INFORMATION

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 800-378-5234 (TTY 800-947-3529). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 800-378-5234 (TTY 800-947-3529). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 800-378-5234 (TTY 800-947-3529)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 800-378-5234 (TTY 800-947-3529)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 800-378-5234 (TTY 800-947-3529). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 800-378-5234 (TTY 800-947-3529). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 800-378-5234 (TTY 800-947-3529) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 800-378-5234 (TTY 800-947-3529). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 800-378-5234 (TTY 800-947-3529) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 5234-378-800 (TTY 3529-947-800). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 800-378-5234 (TTY 800-947-3529). سيقوم شخص ما بمساعدتك. هذه خدمة مجانية يتحدث العربية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 800-378-5234 (TTY 800-947-3529) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 800-378-5234 (TTY 800-947-3529). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 800-378-5234 (TTY 800-947-3529). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 800-378-5234 (TTY 800-947-3529). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 800-378-5234 (TTY 800-947-3529). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、800-378-5234 (TTY 800-947-3529) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Hmong: Peb muaj cov kev pab cuam kws txhais lus pab dawb los teb tej lus nug uas koj muaj hais txog peb li kev noj qab hauv huv los sis lub phiaj xwm tshuaj kho mob. Kom tau txais kws txhais lus pab dawb, tsuas yog hu rau peb ntawm tus xov tooj 800-378-5234 (TTY 800-947-3529). Qee tus neeg uas hais Askiv/Yam Lus koj paub tuaj yeem pab tau rau koj. Qhov no yog kev pab dawb.