Network Health Southeast Wisconsin Medicare Advantage Plans (PPO)

OMB No. 0938-1378 Expires:7/31/2024

ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (Part C)

Who can use this form?
People with Medicare who want to join a Medicare Advantage 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 January1)
• Within three 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.

Individuals experiencing homelessness
• If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

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.
• If you have a monthly premium, 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:

Network Health
Attn: Medicare Enrollment
1570 Midway Pl.,
Menasha, WI 54952

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

How do I get help with this form?
Call Network Health Medicare Advantage Plan at 800-983-7587. TTY users can call 800-947-3529.

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

En español: Llame a Network Health Medicare Advantage Plan al 800-983-7587 (TTY 800-947-3529) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Network Health Southeast Wisconsin Medicare Advantage Plans (PPO)

network health

MedicareRx Prescription Drug Coverage

Section 1 – All fields on this page are required

I would like to enroll in:

☐ Network Health Medicare Go (PPO) **$0** per month

☐ Network Health Medicare Anywhere (PPO) **$35** per month

☐ Network Health Medicare Bravo (PPO) **$0** per month

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

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.

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

Street Address: _____ City: _____

State: _____ Zip Code: _____

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) _____

Please Answer This Important Question

Will you have other prescription drug coverage (like VA, TRICARE) in addition to a Network Health 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: _____

Section 2 – This information is optional

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

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

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**

Paying Your Plan Premium and/or Late Enrollment Penalty

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) 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.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DO NOT pay Network Health Medicare Advantage Plan the Part D-IRMAA.

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

☐ Get a bill each month. Between the 15th and 20th of each month, we will send you a billing statement indicating your balance due.

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a **VOIDED** check or provide the following. The monthly premium will be deducted around the 7th of each month.
Account Holder Name: _____
Bank Routing Number: __ __ __ __ __ __ __ __ __ Bank Account Number: _____
Account type: ☐ Checking ☐ Savings

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. Deduction applies to plan premium only and does not include the supplemental dental rider.
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 the amount for one month premium due from your enrollment effective date to the point withholding begins. You will receive a paper bill for any additional months that are still due prior to your effective date. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

IMPORTANT: Please read and sign

- I must keep both Hospital (Part A) and Medical (Part B) to stay in a Network Health Medicare Advantage Plan.
- By joining this Medicare Advantage Plan, I acknowledge that Network Health Medicare Advantage 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).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Network Health Medicare Advantage Plan coverage begins, I must get all of my medical and prescription drug benefits from Network Health Medicare Advantage Plan. Benefits and services provided by Network Health Medicare Advantage Plan and contained in my Network Health Medicare Advantage Plan *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Network Health Medicare Advantage Plan will pay for benefits or services that are not covered.
- 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 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 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: _____

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.

network health

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) _____.

network health

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.