Short Enrollment Request Form

Name:			**Medicare Number:**
Home Phone Number:			
Permanent Street Address (P.O. Box is not allowed):			**Apt. #**:
City:	**County**:	**State**:	**Zip Code**:

Mailing Address (only if different from your Permanent Street Address):

Street Address: City: State: ZIP Code:

Please fill out the following.

I am currently a member of the plan selected below.

Northeast Wisconsin Plans

- ☐ Network Health Medicare Advantage Platinum*Zero** (PPO) **$0** per month (*Available in the following counties: Calumet, Fond du Lac, Manitowoc, Outagamie, Shawano, Sheboygan, Waupaca, Waushara, Winnebago)
- ☐ Network Platinum*Select* (PPO) **$0** per month
- ☐ Network Health Armor (PPO) **$0** per month
- ☐ Network Platinum*Choice* (PPO) **$31** per month
- ☐ Network Platinum*Plus* (PPO) **$51** per month
- ☐ Network Platinum*Plus* Pharmacy (PPO) **$123** per month
- ☐ Network Platinum*Premier* (PPO) **$177** per month
- ☐ Network Platinum*Premier* Pharmacy (PPO) **$296** per month
- ☐ Network*Cares* (PPO D-SNP) **$0** per month

Plan Effective Date

I would like my new plan to begin on:

_____/____/______
(MM / DD / YYYY)

Southeast Wisconsin Plans

- ☐ Network Health Medicare Go (PPO) **$0** per month (*Not available in Kenosha county)
- ☐ Network Health Medicare Anywhere (PPO) **$35** per month
- ☐ Network Health Medicare Bravo (PPO) **$0** per month

I would like to change to the plan selected below and understand this plan has different health benefits and that the premium is as indicated.

Northeast Wisconsin Plans

- ☐ Network Health Medicare Advantage Platinum*Zero** (PPO) **$0** per month (*Available in the following counties: Calumet, Fond du Lac, Manitowoc, Outagamie, Shawano, Sheboygan, Waupaca, Waushara, Winnebago)
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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.

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

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

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.

☐ 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 a language other than what is listed above. Our office hours are Monday–Friday, from 8 a.m. to 8 p.m. TTY users should 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**

Your Plan Premium

If we determine 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 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 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 RRB. DO NOT pay Network Health Medicare Advantage Plan the Part D-IRMAA.

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 1-800-325-0778). You can also apply for extra help online at 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.

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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: ___________________________ Account type: ☐ Checking ☐ Savings

Bank Routing Number: __ __ __ __ __ __ __ __ __ Bank Account Number: ________________________

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (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.)

Please Read and Sign Below

Network Health Medicare Advantage 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 Network Health Medicare Advantage Plan he/she may be paid based on my enrollment in a Network Health Medicare Advantage 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 Network Health Medicare Advantage Plan 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 Network Health Medicare Advantage Plan coverage begins, I must get all of my health care from Network Health Medicare Advantage Plan except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Network Health Medicare Advantage Plan and other services contained in my Network Health Medicare Advantage Plan *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR NETWORK HEALTH MEDICARE ADVANTAGE 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:**

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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.