TheHealthPlan

Please read carefully, print neatly and return to The Health Plan. Each applicant must complete a separate form. DO NOT PHOTOCOPY THIS INDIVIDUAL ENROLLMENT REQUEST FORM FOR REUSE.

If a licensed agent assisted with this enrollment: Agent Name _____ Agent Writing Number _____

How do I get help with this form?

If you have any questions please call The Health Plan at 1.877.847.7915 (TTY: 711), 8 a.m. to 8 p.m., seven days a week from October 1 through March 31 and 8 a.m. to 8 p.m., Monday through Friday from April 1 through September 30. Or, call Medicare at 1.800.MEDICARE (1.800.633.4227). TTY users can call 1.877.486.2048.

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 January 1)
- Within 3 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.

What happens next?

Send your completed and signed form to: The Health Plan
1110 Main St.
Wheeling, WV 26003-2704

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

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.
- 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.

Section 1 – All fields on this page are required (unless marked optional).

Select the plan you want to join:

☐ SecureCare Option I MA Only HMO (no Rx). Plan number H3672-014. $0 per month
☐ SecureCare Option II HMO. Plan number H3672-013. $35 per month
☐ SecureChoice Option II PPO. Plan number H8604-010. $79 per month.
☐ SecureCare Option I MA Only HMO (no Rx). Plan number H3672-021. $0 per month.
☐ SecureCare Option II HMO. Plan number H3672-020. $65 per month.
☐ SecureChoice Option II PPO. Plan number H8604-011. $112 per month.

Not all plans are available in all counties. Please refer to plan documents for plan and county listings.

To add Optional Supplemental Dental, check box below.

☐ YES, I would like to enroll in the Optional Supplemental Dental plan. I understand that I will be billed an additional premium of $23.60 for HMO plans or $28.90 for PPO plans. See Summary of Benefits for the specific plan for details.

First Name:	Last Name:	(Optional) Middle Initial:

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

Permanent Residence Street Address: (Don't enter a P.O. Box)

City:	State:	(Optional) County:	ZIP Code:

Mailing Address, if different from permanent address: (P.O. Box allowed)
Street: City: State: ZIP Code:

Your Medicare information:

Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to The Health Plan? ☐ Yes ☐ No

Name of other coverage: Member # for this coverage: Group # for this coverage:

_____ _____ _____

IMPORTANT: Read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in The Health Plan
- By joining this Medicare Advantage Plan, I acknowledge that The Health 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 enrollment into this Medicare Advantage plan may automatically disenroll me from any other Medicare health plan and prescription drug plan.
- 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 are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my The Health Plan coverage begins, I must get all of my medical and prescription drug (if applicable) benefits from The Health Plan. Benefits and services provided by The Health Plan and contained in my The Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor The Health Plan will pay for benefits or services that are not covered.
- I understand that I need to abide by the rules of the Medicare Advantage plan.
- I understand that I have the right to appeal service and payment denials made by The Health 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:

Name:	Address:
Phone Number:	Relationship to Enrollee:

Section 2– All fields on this page are optional.

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

Please contact us at 1.877.847.7915 to discuss the options for materials in a language other than English.

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large Print ☐ Audio CD

Please contact The Health Plan at 1.877.847.7915 (TTY: 711) if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week from October 1 through March 31 and 8 a.m. to 8 p.m., Monday through Friday from April 1 through September 30. TTY users can call 711.

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

List your Primary Care Physician (PCP), clinic or health center:

Please contact us at 1.877.847.7915 to discuss options if you wish to receive materials via email.

Paying your plan premium

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, you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay The Health Plan the Part D-IRMAA.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Plan premium payment option (Please note: If you don't select a payment option, you will be billed directly by The Health Plan.)

Select a premium payment option:

☐ Get payment coupons.

☐ Electronic Funds Transfer (EFT) from your bank account each month.

* Additional forms may be needed to complete this authorization. Please contact the plan for details.

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

I get monthly benefits from: ☐ Social Security ☐ RRB

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

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.

If none of these statements applies to you or you're not sure, please contact The Health Plan at 1.877.847.7915 (TTY users should call 711) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., seven days a week from October 1 through March 31 and 8 a.m. to 8 p.m., Monday through Friday from April 1 through September 30.

AGENT USE ONLY
Appointment Type: _____ Scope of Appointment ID Number: _____
Print Agent name _____
Agent Writing Number (AWN) _____ Agent Phone Number _____

NOTE: If Agent takes receipt of this application, signature and date are required below:
Signature of Agent _____
Date Individual Enrollment Request Form received By Agent _____
Agent: Please be sure to copy and maintain this and all pages of the completed application for your records.

OFFICE USE ONLY:
Name of staff member/agent/broker (if assisted in enrollment): _____ Agent ID: ____
Plan ID #: _____ Group #: _____ Member/Client ID: _____
Effective Date of Coverage: _____ Date Received: _____
Check Number: _____ Check Amount: _____
ICEP/IEP: _____ AEP: _____ OEP: _____ SEP (type): _____ Not Eligible: _____