HealthSun
HEALTH PLANS

2018 Enrollment Form

HealthSun Health Plans is an HMO plan with a Medicare contract. Enrollment in HealthSun Health Plans depends on contract renewal. You must continue to pay your Medicare Part B Premium. Benefits, premiums, and/or co-payments/co-insurance may change on January 1 of each year. HealthSun complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-336-2069. (TTY: 1-877-206-0500). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-336-2069. (TTY: 1-877-206-0500).

Proposed Effective Date

Please contact HealthSun Health Plans if you need information in another language or format (Braille).
To enroll in HealthSun Health Plans, please provide the following information:
Please check which plan you want to enroll In:

☐ 001 – HealthSun SunPlus Advantage Plan (HMO): $0 per mo.
☐ 012 – HealthSun HealthAdvantage Plan (HMO): $0 per mo.
☐ 006 – HealthSun MediMax Plan (HMO): $29.10 per mo.

Please Provide Your Medicare Insurance Information:
Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

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.

Mr. / Mrs. / Ms.

Last Name: _____ First Name: _____ Middle Initial: _____

Birth Date: ____ /____ /____ Sex: _____ Home Phone Number: _____

Permanent Residence Street Address: _____

City: _____ County: _____ State: _____ ZIP Code: _____

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

Street Address: _____

City: _____ County: _____ State: _____ ZIP Code: _____

Emergency Contact: _____ Relationship to you: _____

Phone Number: _____ Alternate Phone Number: _____

Please choose a Primary Care Physician (PCP), clinic or health center:

PCP Name (print): _____ **PCP #:** _____

Paying Your Plan Premium

If we determine that 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, each month or quarterly. 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 the RRB. DO NOT pay HealthSun Health Plans the Part D- IRMAA.

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, each month or quarterly. 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 HealthSun Health Plans 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% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. 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 users should call 1 (800) 325-0778. You can also apply for extra help online at www.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. 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.

Please select a premium payment option:

☐ Get a Bill

☐ 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/RBR 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 premium.)

Please read and answer these important questions

1. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No
If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to HealthSun Health Plans? ☐ 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:

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
If "yes", please provide the following information:

Name of Institution: _____

Address & Phone Number of Institution (number and street):

_____

4. Are you enrolled in your State Medicaid Program? ☐ Yes ☐ No
If yes, please provide your Medicaid number: _____

5. Do you or your spouse work? ☐ Yes ☐ No

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

☐ Spanish

☐ Other language: _____.

☐ Other format (such as braille or large print) _____,

Please contact HealthSun Health Plans at (305) 447-4458 or 1 (877) 336-2069 if you need information in another format or language than what is listed above. Our office hours are Monday through Fridays, from 8am to 8pm. TTY users should call 1 (877) 206-0500.

PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining HealthSun Health Plans could affect your employer or union health benefits. You could lose your employer or union health coverage if you join HealthSun Health Plans. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below

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

HealthSun Health Plans 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 or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

HealthSun Health Plans serves a specific service area. If I move out of the area that HealthSun Health Plans 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 HealthSun Health Plans, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from HealthSun Health Plans when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date HealthSun Health Plans coverage begins, I must get all my health care from HealthSun Health Plans, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by HealthSun Health Plans and other services contained in my HealthSun Health Plans Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTHSUN HEALTH PLANS WILL PAY FOR THE SERVICES.**

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

Release of Information: By joining this Medicare health plan, I acknowledge that HealthSun Health Plans will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that HealthSun Health Plans 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 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 by HealthSun Health Plans or by Medicare.

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between October 15 and 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 initial next to the statement(s) that applies to you. By marking your initials on any of the following lines 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.

Enrollment Period Statements

_____ I am new to Medicare.

_____ 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 returned to the United States after living permanently outside of the US. I returned to the US on (insert date): _____.

_____ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.

_____ I get extra help paying for Medicare prescription drug coverage.

_____ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date): _____.

_____ I recently was released from incarceration. I was released on (insert date): _____.

_____ I recently obtained lawful presence status in the United States. I got this status on (insert date): _____.

_____ 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 of All-Inclusive Care for the Elderly) 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 Special Needs Plan (SNP) but I have lost the special needs qualification required to be in the plan. I was disenrolled from the SNP on (insert date): _____.

If none of these statements applies to you or you're not sure, please contact HealthSun Health Plans at (305) 447-4458 or 1 (877) 336-2069 (TTY users should call 1 (877) 206-0500) to see if you are eligible to enroll. We are open Monday through Friday, from 8am to 8pm. HealthSun Health Plans is an HMO plan with a Medicare contract. Enrollment in HealthSun Health Plans depends on contract renewal.

Your Signature: _____ **Today's Date:** _____

If you are the authorized representative, you must sign above and provide the following information:

Name: _____ Relationship to Enrollee: _____

Address: _____ Phone Number: _____

Office Use Only:

Name of Sales Agent (Print): _____

Signature of Sales Agent: _____

HealthSun Agent ID#: _____ **Plan ID #:** _____ **Effective Date of Coverage:** _____

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

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