Short Enrollment Request Form

Switch from Plan to Plan within HealthSun

Name of Plan You are Enrolling In:			
Name:		**Member Number:**	
Home Phone Number:			
Permanent Street Address *(P.O. Box is not allowed):*			
City:	**County:**	**State:**	**ZIP Code:**
Mailing Address *(only if different from your Permanent Street Address):*			
City:	**County:**	**State:**	**ZIP Code:**

Please fill out the following:

I am currently a member of the following HealthSun plan *(check one):*

- ☐ Plan 001 HealthSun SunPlus Advantage (HMO) - Monthly Plan Premium: $0
- ☐ Plan 006 HealthSun MediMax (HMO) – Monthly Plan Premium: $30.30
- ☐ Plan 012 HealthSun HealthAdvantage (HMO) - Monthly Plan Premium: $0

I would like to change to the following HealthSun plan *(check one)*:

- ☐ Plan 001 HealthSun SunPlus Advantage (HMO) - Monthly Plan Premium: $0
- ☐ Plan 006 HealthSun MediMax (HMO) – Monthly Plan Premium: $30.30
- ☐ Plan 012 HealthSun HealthAdvantage (HMO) - Monthly Plan Premium: $0

I understand that this plan has different health benefits and may have a different monthly plan premium.

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 accessible formats (like Braille, audio tape, or large print).

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

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 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 you 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 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 Railroad Retirement Board. 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 you qualify, 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 won't have a coverage gap or a late enrollment penalty. Many people qualify 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 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.

Please select a premium payment option:

☐ Get a bill

☐ Automatic deduction from your monthly Social Security or RRB benefit check:
I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security 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.)

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.

_____ Other: _____.

If none of these statements applies to you or you're not sure, please contact HealthSun Health plans at (877) 336-2069 (TTY: (877) 206-0500) to see if you are eligible to enroll. We are open Monday through Friday from 8am to 8pm.

Please Read and Sign Below:

HealthSun Health Plans 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 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 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 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 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 HealthSun Health Plans coverage begins, I must get all of 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 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:

Name: _____

Address: _____

Phone Number:_____

Relationship to Enrollee: _____

Office Use Only:

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

Plan ID #_____

Effective Date of Coverage: _____

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