Individual Enrollment Request Form to Enroll in a Medicare Advantage Plan (Part C)

Samaritan Health Plans

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.

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.

What happens next?

Send your completed and signed form to: **Samaritan Health Plans, PO Box M, Corvallis, OR 97339**. Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Samaritan Health Plans at 1-866-747-5267. TTY users can call 800-735-2900.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

En español: Llame a Samaritan Health Plans al 1-866-747-5267 (TTY: 800-735-2900) o a Medicare gratis al 1-800-633-4227 (durante las 24 horas, los 7 días de la semana) (TTY: 1-877-486-2048) y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

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.

2024 individual enrollment request form

Samaritan Health Plans

Please contact Samaritan Health Plans if you need information in another format (Braille).
All fields are required except those denoted with an asterisk (*).

To enroll in Samaritan Advantage Health Plans (HMO), please provide the following information:

Please check which plan you want to enroll in:

☐ Samaritan Dual Advantage (HMO) $0 per month

☐ Mr. ☐ Mrs. ☐ Ms.

Last name: _____ First name: _____ Middle initial*: _____

Birth date: (MM/DD/YYYY): _____ Sex: ☐ M ☐ F

Home phone number: _____

Alternate phone number: _____

Permanent residence street address (P.O. Box is not allowed): _____

City: _____ County*: _____ State: _____ ZIP code: _____

Email address: _____

Mailing address (only if different from your permanent residence address):

Street address: _____

City: _____ State: _____ ZIP code: _____

Emergency contact: _____

Relationship to you: _____ Phone number: _____

Please provide your Medicare insurance information:

Medicare number: _____

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) _____.
- ☐ 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 Samaritan Advantage Health Plans at 541-768-4550 or 800-832-4580 (TTY users should call 800-735-2900) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m. daily Oct. 1 through March 31 and 8 a.m. to 8 p.m. Monday through Friday April 1 through Sept. 30.

Please read and answer these important questions

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 Samaritan Advantage 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:**

_____ _____ _____

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: _____ Phone number: _____

Address of institution (number and street):: _____

All fields in this section are 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

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, Puerto Rican
- ☐ Yes, Cuban
- ☐ 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
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Black or African American
- ☐ Native Hawaiian and Pacific Islander
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ White
- ☐ **I choose not to answer.**

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

☐ Braille ☐ Large print ☐ Audio CD

Please contact Samaritan Advantage Health Plans at 541-768-4550 or 866-747-5267 (TTY 800-735-2900) if you need information in an accessible format or language other than what is listed above. Our hours are 8 a.m. to 8 p.m. daily from Oct. 1 to March 31, and 8 a.m. to 8 p.m. Monday through Friday from April 1 to Sept. 30.

IMPORTANT: Please read and sign below

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

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Samaritan Advantage Health Plan.
- By joining this Medicare Advantage plan, I acknowledge that Samaritan Advantage 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 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 Samaritan Advantage Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Samaritan Advantage Health Plan. Benefits and services provided by Samaritan Advantage Health Plan and contained in my Samaritan Advantage Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Samaritan Advantage Health 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're the authorized representative, sign above and fill out these fields:

Name: _____

Address: _____

Phone number: _____ Relationship to enrollee: _____

Samaritan Advantage Health Plans is an HMO with a Medicare contract. Enrollment in Samaritan Advantage Health Plans depends on contract renewal. Samaritan Health Plans complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Agents only complete this section.

Agent NPN#: _____

Agency/FMO affiliation (if applicable): _____

Agent ID#: _____
This information must match your approved Samaritan Health Plans licensing records.

Agent phone: _____ Email: _____

Agency/FMO phone (if applicable): _____

Sales representative/authorized agent application receipt date: _____
Applications must be received at Samaritan Health Plans within one (1) calendar day of this date.

Broker Application Submissions: Sales representative/Agent must fax the Scope of Appointment and Enrollment Forms to **1-541-768-9778** Attention: Enrollment or email them to SHPOMemberEnrollment@samhealth.org.

Please read this important information

If you currently have health coverage from an employer or union, joining Samaritan Advantage Health Plans could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Samaritan Advantage 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.

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: _____

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 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.