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 866-207-3182 (TTY 800-735-2900).

Or, call Medicare at 800-MEDICARE (800-633-4227). TTY users can call 877-486-2048.

En español: Llame a Samaritan Health Plans al 866-207-3182 (TTY 800-735-2900) o a Medicare gratis al 800-633-4227 y oprima el 8 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.

2026 Individual Enrollment Request

Samaritan Health Plans

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

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

☑ Samaritan Dual Advantage (HMO) – $10.50 per month (most members pay $0)

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

Birth date: (MM/DD/YYYY): _____ Sex: ❑ M ❑ F Home phone number: _____ Mobile phone number*: _____

Permanent residence street address

(Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

Street address: _____

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*

Emergency contact: _____

Relationship to you: _____ Phone number: _____

Please provide your Medicare insurance information:

Medicare number: ____ ____ ____ ____ – ____ ____ ____ – ____ ____ ____ ____

Medicare Part A effective date*: _____ Medicare Part B effective date*: _____

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 recently moved and have new options available to 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 (U.S.) 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 U.S. I got this status on (insert date) _____.
- ❑ I recently had a change in Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ❑ I recently had a change in 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 Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).
- ❑ 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'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ❑ 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 an emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state, or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request 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 **866-207-3182** (TTY **800-735-2900**) or **541-768-7866** 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

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:**

_____ _____ _____

You must also have Medicaid coverage to join this plan. Please list your Medicaid ID below:

Medicaid ID: _____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) coverage to stay enrolled in Samaritan Advantage Health Plans.
- By joining this Medicare Advantage (MA) plan, I acknowledge that Samaritan Advantage Health Plans will share my information with Medicare, who may use it to track my enrollment, to make payments or 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 Plans coverage begins, I must get all of my medical and prescription drug benefits from Samaritan Advantage Health Plans. Benefits and services provided by Samaritan Advantage Health Plans and contained in my Samaritan Advantage Health Plans "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Samaritan Advantage Health Plans 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 an authorized representative, please sign above and fill out the following fields:

Name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Phone number: _____ Relationship to enrollee: _____

Additional new member information

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

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

Select one if you want us to send you information in a language other than English. ❑ Spanish

If you need information in an accessible format, please select all that apply:

❑ Braille ❑ Large print ❑ Audio CD ❑ Data CD

Please contact Samaritan Advantage Health Plans at **866-207-3182** (TTY **800-735-2900**) or **541-768-7866** 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.

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (e.g., agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____

Relationship to enrollee: _____

Signature: _____

Agent NPN#: _____

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

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.