Individual enrollment request form

Samaritan Health Plans

Please contact Samaritan Health Plans if you need information in another format (Braille).

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

Please check which plan you want to enroll in:

- ☐ Samaritan Advantage Conventional Plan (HMO) $50 per month
- ☐ Samaritan Advantage Premier Plan (HMO) $19 per month
- ☐ Samaritan Advantage Premier Plan Plus (HMO) $129 per month

☐ Mr. ☐ Mrs.
Last name: _____ First name: _____ Middle initial: _____ ☐ Ms.

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:

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.

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.

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, Electronic Funds Transfer (EFT), credit/debit 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 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 Samaritan Advantage Health Plan 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 800-772-1213. TTY users should call 800-325-0778. You can also apply for Extra Help online at **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 monthly.

☐ Electronic funds transfer (EFT) from your bank account each month.
Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: _____ Bank account number: _____

Account type: ☐ Checking ☐ Saving

☐ Credit Card. Please provide the following information:

Type of card: _____

Name of account holder as it appears on card: _____

Account number: _____ Expiration date: __ __ / __ __ __ __ (MM/YYYY)

☐ 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/RRB 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.)

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: _____

Address and phone number of institution (number and street):

_____

Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If yes, please provide your Medicaid number: _____

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

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.

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
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ 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 800-832-4580 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.

Please read and sign below

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

Samaritan Advantage Health Plan 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. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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.

Samaritan Advantage Health Plan serves a specific service area. If I move out of the area that Samaritan Advantage Health Plan 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 Samaritan Advantage Health Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Samaritan Advantage Health Plan when I get it to know which rules I must follow to get coverage with this Medicare Advantage Health 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 Samaritan Advantage Health Plan coverage begins, I must get all of my health care from Samaritan Advantage Health Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Samaritan Advantage Health Plan and other services contained in my Samaritan Advantage Health Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **neither Medicare nor Samaritan Advantage Health Plan 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 Samaritan Advantage Health Plan, he/she may be paid based on my enrollment in Samaritan Advantage Health Plan.

Release of Information: By joining this Medicare health plan, I acknowledge that Samaritan Advantage 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 Samaritan Advantage Health Plan 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 from 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: _____

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.

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.