OMB No. 0938-1378
Expires: 7/31/2024

# Individual Enrollment Request Form

## 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
- Be a resident in a Dignity Health Plan contracted nursing home facility

*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 your monthly Social Security (or Railroad Retirement Board) benefit.

## What happens next?

*Send your completed and signed form to:*

Dignity Health Plan
201 Jordan Rd, Suite 200
Franklin, TN 37067

*Once they process your request to join, they'll contact you.*

## How do I get help with this form?

Call Dignity Health Plan at 1-866-266-6010. TTY users can call 1-833-312-0046, or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

*En Español:* Llame a Dignity Health Plan al 1-866-266-6010/TTY 1-833-312-0046 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

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## Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

☐ Dignity Health Plan (HMO I-SNP) [H8492-001] – $38.00 per month

First name:_____ Middle initial: _____ Last name: _____
Birth date: (MM/DD/YYYY) (__ __ /__ __ / __ __ __ __) Sex: __ Male __ Female
Phone number: (_____) _____ - _____

Permanent residence street address (please do not enter a P.O. box)
Street: _____
City: _____ State: _____ Zip code: _____County: _____

Mailing address, *if different from your permanent address* (P.O. box allowed)
Street: _____
City: _____ State: _____ Zip code: _____County: _____

## Your Medicare information

Medicare number: ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

## Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Dignity Health Plan?
Yes ☐ No ☐
Name of other coverage: _____
Member number for this coverage: _____ Group number for this coverage:_____

Do you reside at home or in an assisted living facility? ☐ Yes ☐ No
If *yes*, has the state that you reside in certified that you need the type of care that is usually provided in a nursing home? ☐ Yes ☐ No

Are you a resident of or expect to be a resident of a long-term care facility or an assisted living facility in the Dignity Health Plan network for more than 90 days? ☐ Yes ☐ No
If *yes,* please provide the following information:
Name of facility: _____
Facility address: _____
City: _____ State: _____ Zip code: _____County: _____

OMB No. 0938-1378
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## IMPORTANT: Read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Dignity Health Plan.
- By joining this Medicare Advantage Plan, I acknowledge that Dignity 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.
- 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 are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Dignity Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Dignity Health Plan. Benefits and services provided by Dignity Health Plan and contained in my Dignity Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Dignity Health Plan will pay for benefits or services that are not covered.
- 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 are the authorized representative, sign above and fill out the fields below:*

Name: _____

Street address: _____

City: _____ State: _____ Zip code: _____County: _____

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: _____

## Section 2 – All fields on this page 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, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **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. ☐ Large print

Please contact Dignity Health Plan at 1-866-266-6010 if you need information in an accessible format other than a large print format.
Our office hours are:

October 1 – March 31
8:00 am – 8:00 pm, seven days a week

April 1 – September 30
8:00 am – 8:00 pm, Monday – Friday

*TTY users can call 1-833-312-0046.*

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

List your primary care physician (PCP), clinic, or health center:

_____

## Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

**If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium.** The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Dignity Health Plan the Part D-IRMAA.

Please select a premium payment option:

- ☐ Get a bill each month
- ☐ 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 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.)

If a premium payment option is not selected above, the default action will be direct bill.

**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 and 1860D-1 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.