Health Alliance Plan®
by Henry Ford Health

OMB No. 0938-1378
Expires: 02/28/2029

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

HAP Medicare Diabetes and Heart (HMO C-SNP)

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:

Health Alliance Plan
Attn: Medicare Sales
1414 E Maple Rd
Troy, MI 48083

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

How do I get help with this form?

Call Health Alliance Plan at **(800) 868-3153.** TTY users can call **711.**

Or, call Medicare at **1-800-MEDICARE (1-800-633-4227).** TTY users can call **1-877-486-2048.**

En español: Llame a Health Alliance Plan al **(800) 868-3153 (TTY: 711)** o a Medicare gratis al **1-800-633-4227** 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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

HAP Medicare Diabetes and Heart (HMO C-SNP) has a contract with Medicare. Enrollment depends on contract renewal.

HAP Medicare Diabetes and Heart (HMO C-SNP) Individual Enrollment Request Form

Health Alliance Plan
by Henry Ford Health

Health Alliance Plan • 1414 E Maple Rd, Troy, MI 48083 • (800) 868-3153 (TTY: 711)

Section 1 — All fields in this section are required (unless marked optional)

☐ **HAP Medicare Diabetes and Heart (HMO C-SNP)** (030) with prescription drugs | 61 county service area	**Monthly premium** $6.30* *Premium may be reduced or covered if you qualify for Extra Help (Low-Income Subsidy)

FIRST name:	LAST name:	Middle initial:	☐ Mr. ☐ Mrs. ☐ Ms.

Birth date: (MM/DD/YYYY) __ __ / __ __ / __ __ __ __	Sex: ☐ Male ☐ Female
Email address:	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.):

City:	County:	State:	ZIP code:

Mailing address, if different from your permanent address (PO box allowed):

Street address: PO box:

City:	State:	ZIP code:

Your Medicare information:

Medicare number: __ __ __ __ / __ __ __ / __ __ __ __

Medicare Part A effective date: __ __ / __ __ __ __

Medicare Part B effective date: __ __ / __ __ __ __

Agent use only

Agent/broker name:	
Agent national producer number:	
Agent received date:	Effective date of coverage:
ICEP/IEP:	AEP:
SEP (type):	

Answer these important questions:

1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Health Alliance Plan? ☐ Yes ☐ No

   Name of other coverage: _____

   Member number for this coverage: _____

   Group number for this coverage: _____

2. Are you enrolled in your state Medicaid program? ☐ Yes ☐ No

   Medicaid number: _____

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

   Name of facility: _____

   Address (number and street) and phone number of facility: _____

4. Do you have any chronic conditions, such as cardiovascular disorders, chronic heart failure and/or diabetes? ☐ Yes ☐ No

IMPORTANT: Read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in this Health Alliance Plan Medicare Advantage plan.
- By joining this Medicare Advantage plan, I acknowledge that Health Alliance 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 Health Alliance Plan Medicare Advantage plan coverage begins, I must get all of my medical and prescription drug benefits from Health Alliance Plan. Benefits and services provided by Health Alliance Plan and contained in my Health Alliance Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Health Alliance Plan will pay for benefits or services that are not covered.
- I understand that by providing my email address and phone number, I am agreeing to periodic emails and text messages from Health Alliance Plan regarding my 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 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:** _____

For individuals helping enrollee with completing this form only

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

Name:_____

Address: _____

Email address: _____

Phone number:_____ Relationship to enrollee: _____

Signature:_____

National producer number (agents/brokers): _____

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.

Section 2 – 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.

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

☐ Yes ☐ No

Please contact Health Alliance Plan at (800) 868-3153. Our office hours are Monday through Friday, 8 a.m. to 8 p.m. ET. TTY users can call 711.

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

☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Please contact Health Alliance Plan at (800) 868-3153 if you need information in an accessible format other than what's listed above. Our office hours are Monday through Friday, 8 a.m. to 8 p.m. ET. TTY users can call 711.

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

For the HAP Medicare Diabetes and Heart (HMO C-SNP) plan, please list your Primary Care Physician (PCP), clinic or health center:

Medical center or PCP name: _____

I want to get the following materials via email. Select one or more.

☐ Annual Notice of Change (ANOC)
☐ Evidence of Coverage (EOC)
☐ Enrollment application
☐ Physician directory
☐ Pharmacy directory
☐ Formulary

Email address: _____

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by selecting one of the options below. (Skip this section if you are enrolling in a Health Alliance Plan Medicare Advantage plan with no premium, and you did not select the optional dental plan.)

If you don't select a payment option, you will receive a bill each month.

☐ **Receive a bill and pay by mail**

☐ **Register at hap.org/welcome to access Pay My Bill, where you can select one of five payment options:**
- Make a one-time payment online 24/7
- Pay with a credit or debit card
- Set up automatic monthly payments (auto pay) using a checking or savings account or credit card

☐ **Electronic Funds Transfer (EFT) from your bank account each month.** Please provide the following:

Account holder name:			
Banking routing number:		Bank account number:	
Account type: ☐ Checking ☐ Savings			

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.

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.**

I get monthly benefits from:

☐ Social Security ☐ Railroad Retirement Board (RRB)

For plans without prescription drugs:

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. I must get all of my healthcare from Health Alliance Plan, except for emergency or urgently needed services or out-of-area dialysis services.

For plans with prescription drugs:

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. Don't pay Health Alliance Plan the Part D-IRMAA.

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. **For options that require a date, please insert the date as MM/DD/YYYY.**

☐ 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 (OEP).

☐ I recently moved outside of the service area for my current plan or I recently moved and have new options available to me. I moved on (insert date) (__ __ / __ __ / __ __ __ __).

☐ I was recently 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 Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan or D-SNP).

☐ I am moving into, live in or recently moved out of a long-term care facility (for example, a nursing home). 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 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.

☐ I am enrolling in a Health Alliance Plan Medicare Advantage plan between the dates of October 15 through December 7.

If none of these statements apply to you or you're not sure, please contact Health Alliance Plan at (800) 868-3153 (TTY: 711) to see if you are eligible to enroll.

We are open:
Oct. 1 – March 31 from 8 a.m. to 8 p.m., Seven days a week
April 1 – Sept. 30 from 8 a.m. to 8 p.m., Monday through Friday