EMPOWERED DUALS
(HMO SNP)

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HAP EMPOWERED DUALS (HMO SNP) INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C) OR MEDICARE PRESCRIPTION DRUG PLAN (PART D)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug 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)

To join a HAP Empowered Duals (HMO SNP) plan you must be eligible for both Medicare and full Medicaid.

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.
- As a member of our plan, you pay a monthly plan premium. Some people with Medicaid coverage get help paying for their Medicare premiums. If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.

What happens next?

Send your completed and signed form to:

Health Alliance Plan
Attn: Medicare Sales
2850 W. Grand Blvd
Detroit, Michigan 48202

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

How do I get help with this form?

Call HAP Empowered Duals (HMO SNP) 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.

If you speak any language other than English, language assistance services, free of charge, are available to you. Call HAP Medicare Advantage at (800) 868-3153. Our office hours are Monday through Friday, 8 a.m. to 8 p.m. ET. TTY/TDD

Answer these important questions:

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or state pharmaceutical assistance programs. If you are enrolling in a HAP Medicare Advantage plan that offers prescription coverage, will you have other prescription drug coverage?

   Yes No If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of Other Coverage: _____

   Coverage ID #: _____

   Coverage Group #: _____

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

   If yes, please provide your Medicaid number: _____

3. Do you have a current Medicaid plan provider? Yes No

   If yes, please provide what company, and what plan do you have? _____

   _____

4. 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 & Phone Number of Institution (number and street): _____

IMPORTANT: Read and sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in HAP Medicare Advantage.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that HAP Medicare Advantage 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 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 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 if I am getting assistance from a sales agent, broker or other individual employed by or contracted with HAP Empowered Duals (HMO-SNP), he/she may be paid based on my enrollment in a HAP Medicare Advantage plan.
- I understand that when my HAP Empowered Duals (HMO-SNP) coverage begins, I must get all my medical and prescription drug benefits from HAP Empowered Duals (HMO-SNP). Benefits and services provided by HAP Medicare Advantage and contained in my HAP Empowered Duals (HMO-SNP) "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor HAP Empowered Duals (HMO-SNP) will pay for benefits or services that are not covered.

EMPOWERED DUALS
(HMO SNP)

HAP Empowered Duals (HMO SNP) Individual Enrollment Request Form

Health Alliance Plan • 2850 W. Grand Blvd., Detroit, MI 48202 • (800) 868-3153 (TTY: 711)
Please contact HAP Medicare Advantage if you need information in another format (large format).

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

FIRST Name: LAST Name: Middle Initial:			☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)		Sex: ☐ Male ☐ Female	
Email Address:		Preferred Phone Number:	
Permanent Residence Street Address (P.O. Box is not allowed)			
City:	County:	State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address) Street Address: PO Box:			
City:	County:	State:	ZIP Code:

Your Medicare information:

Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _

Agent Use Only

Name of Staff Member/Agent/Broker (if assisted in enrollment):

Agent NPN:

Agent Received Date: Effective Date of Coverage:

ICEP/IEP: AEP:

Plan ID:

SEP (type): Not Eligible:

Answer these important questions:

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or state pharmaceutical assistance programs. If you are enrolling in a HAP Medicare Advantage plan that offers prescription coverage, will you have other prescription drug coverage?
   ☐ Yes ☐ No If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:
   Name of Other Coverage: _____
   Coverage ID #: _____
   Coverage Group #: _____
2. Are you enrolled in your state Medicaid program? ☐ Yes ☐ No
   If yes, please provide your Medicaid number: _____
3. Do you have a current Medicaid plan provider? ☐ Yes ☐ No
   If yes, please provide what company, and what plan do you have? _____
   _____
4. 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 & Phone Number of Institution (number and street): _____

IMPORTANT: Read and sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in HAP Medicare Advantage.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that HAP Medicare Advantage 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 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 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 if I am getting assistance from a sales agent, broker or other individual employed by or contracted with HAP Empowered Duals (HMO-SNP), he/she may be paid based on my enrollment in a HAP Medicare Advantage plan.
- I understand that when my HAP Empowered Duals (HMO-SNP) coverage begins, I must get all my medical and prescription drug benefits from HAP Empowered Duals (HMO-SNP). Benefits and services provided by HAP Medicare Advantage and contained in my HAP Empowered Duals (HMO-SNP) "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor HAP Empowered Duals (HMO-SNP) will pay for benefits or services that are not covered.

- If you lose your Medicaid eligibility but can reasonably be expected to regain eligibility within 90 days, then you are still eligible for membership in our plan.
- If you currently have health coverage from an employer or union, joining a HAP Medicare Advantage plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join a HAP Medicare Advantage plan. 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.
- 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, you must sign above and provide the following information:

Name: _____

Address: _____

Email Address: _____

Phone Number: _____ Relationship to Enrollee: _____

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.

If you speak any language other than English, language assistance services, free of charge, are available to you. Call HAP Medicare Advantage at (800) 868-3153. Our office hours are Monday through Friday, 8 a.m. to 8 p.m. ET. TTY/TDD

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

☐ Large Print ☐ Audio Tape

Please contact HAP Medicare Advantage at (800) 868-3153. Our office hours are Monday through Friday, 8 a.m. to 8 p.m. ET. TTY/TDD users should call TTY: 711.

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

Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No

Please choose the name of a Primary Care Physician (PCP), clinic or health center:

Medical Center Name: _____

Primary Care Physician Name: _____

Primary Care Physician ID #: _____

Paying your premium

For most HAP Empowered Duals (HMO SNP) members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium. If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan. If you receive "Extra Help" from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty. If you ever lose your low income subsidy ("Extra Help"), you would be subject to the monthly Part D late enrollment penalty if you have ever gone without creditable prescription drug coverage for 63 days or more. If you are required to pay the Part D late enrollment penalty, the cost of the late enrollment penalty depends on how long you went without Part D or creditable prescription drug coverage.

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 coinsurance. 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 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.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.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

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: MM/DD/YYYY) (__ __ / __ __ / __ __ __ __).
- ☐ 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 Medicare prescription drug coverage.
- ☐ 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.

(*Continued on next page*)

- ◯ 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 HAP Medicare Advantage at (800) 868-3153 (TTY users should call TTY: 711) to see if you are eligible to enroll.

We are open:

8 a.m. to 8 p.m., seven days a week (Oct. 1 - March 31)

8 a.m. to 8 p.m., Monday through Friday (April 1 - Sept. 30)