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MEDICARE SOLUTIONS

HAP MEDICARE ADVANTAGE 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)

When do I use this form?

You can use this form:

- AEP, between October 15-December 7 each year
- OEP, between January 1 - March 31 each year
- 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.

- 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
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 Medicare Advantage 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

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.

Health Alliance Plan (HAP) has HMO, HMO-POS, PPO plans with Medicare contracts. Enrollment depends on contract renewal.

Medicare Advantage 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:	
By providing your email and preferred phone to HAP you are agreeing to periodic emails and text messages from HAP regarding your plan.			
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: _ _ _ _ - _ _ _ - _ _ _ _

Medicare Part A effective date: _ _ / _ _ _ _

Medicare Part B effective date: _ _ / _ _ _ _

Agent Use Only

Agent/Broker Name:

Agent NPN:

Agent Received Date: Effective Date of Coverage:

ICEP/IEP: ☐ AEP: ☐

Plan ID:

SEP (type):

Select the plan you want to join (check only one):

Please check which plan you want to enroll in (*check only one*):

	Monthly Premium		Monthly Premium
HAP Senior Plus (HMO)		**HAP Senior Plus (HMO-POS)**	
◯ HMO (015) with prescription drugs *46 County Service Area*	$0	◯ Option 1 with prescription drugs *30 County Service Area*	$99
◯ HMO (019) Medical Only without prescription drugs *46 County Service Area*	$0	◯ Option 2 with prescription drugs *30 County Service Area*	$190
HAP Regional (HMO) Plans		**HAP Senior Plus (PPO)**	
◯ HAP Senior Plus Henry Ford Tiered Access with prescription drugs *3 County Service Area*	$99	◯ Option 1 with prescription drugs *36 County Service Area*	$0
◯ HAP Primary Choice with prescription drugs *7 County Service Area*	$0	◯ Option 2 with prescription drugs *36 County Service Area*	$70
		◯ Option 3 with prescription drugs *36 County Service Area*	$165
		◯ Option 4 with prescription drugs *36 County Service Area*	$180
◯ **HAP MSUHC Medicare (HMO)** with prescription drugs *46 County Service Area*	$0	◯ **HAP Medicare Flex (PPO)** with prescription drugs *36 County Service Area*	$0

Optional Dental Plans :

◯ **Delta 50** - $20.00 additional monthly premium plan

◯ **Delta 70** - $39.30 additional monthly premium plan

◯ **Delta 100** - $46.60 additional monthly premium plan

Answer these important questions:

1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to HAP Medicare Advantage plan?
   ☐ 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. 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.
- 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 HAP Medicare Advantage coverage begins, I must get all my medical and prescription drug benefits from HAP Medicare Advantage. Benefits and services provided by HAP Medicare Advantage and contained in my HAP Medicare Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor HAP Medicare Advantage 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 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.

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 a language other than English. ☐ Yes ☐ No

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

For HAP Senior Plus (HMO, HMO-POS, Regional (HMO), (PPO). HAP Medicare Flex (PPO) and MSU Health Care Medicare (HMO) plans, 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

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 HAP Medicare Advantage zero premium plan, and you did not select an 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

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or 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 HAP Medicare Advantage, 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 Medicare Advantage the Part D-IRMAA.

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)