GlobalHealth Medicare Advantage Plans

Individual Enrollment Request Form (For New Members Only)

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 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: MM/DD/YYYY
- ☐ I recently was released from incarceration. I was released on: MM/DD/YYYY
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on: MM/DD/YYYY
- ☐ I recently obtained lawful presence status in the United States. I got this status on: MM/DD/YYYY
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on: MM/DD/YYYY
- ☐ 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: MM/DD/YYYY
- ☐ I recently left a PACE program on: MM/DD/YYYY
- ☐ I recently involuntarily lost my credible prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on: MM/DD/YYYY
- ☐ I am leaving employer or union coverage on: MM/DD/YYYY
- ☐ 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 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: MM/DD/YYYY

If none of these statements applies to you or you're not sure, please contact GlobalHealth at 405-280-5555 or 844-280-5555 (TTY users should call 711) to see if you are eligible to enroll. We are open 8:00 a.m. to 8:00 p.m., 7 days a week (October 1 - February 14) and Monday - Friday (February 15 - September 30).

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Please contact GlobalHealth if you need information in another language or format.

SECTION 1	To Enroll in a GlobalHealth Medicare Advantage Plan Please Provide the Following Information:

Please check which plan you want to enroll in:

- ❑ $0 Generations Value (MA-Only)
- ❑ $29 Generations Select (MA-PD)
- ❑ $0 Generations Classic (MA-PD)

Last Name: First Name: MI: ❑ Mr. ❑ Mrs. ❑ 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: State: ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):
Street Address:

City: State: ZIP Code:

SECTION 2	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)	MM/DD/YYYY
MEDICAL (Part B)	MM/DD/YYYY

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

H3706_ENROLLMENTFORMV2_PY2018 Accepted

SECTION 3 — Paying Your Plan Premium

For **Generations Value**, please continue to Section 4 of this application.

For **Generations Classic:**
If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail, Electronic Funds Transfer (EFT), or credit card 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 the RRB. DO NOT pay GlobalHealth the Part D-IRMAA.

For **Generations Select**:
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), or credit card 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 the RRB. DO NOT pay GlobalHealth the Part D-IRMAA.

For **Generations Classic & Generations Select**:
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 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 only pays a portion of this premium, we will bill you for the amount Medicare doesn't cover.

SECTION 3 (cont.)	Paying Your Plan Premium

If you don't select a payment option, you will get a bill each month.
Please select a premium payment option:

❑ Get a Bill

❑ 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

Name
Address
City, State Zip
2008
Date
Pay to the order of
$
Dollars
Memo
VOID
⑆123456789⑆ ⑈12 3456789⑈ 2008
Routing Number
Account Number

❑ 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 ATTACH VOIDED CHECK HERE

SECTION 4 — Please Read and Answer These Important Questions:

1. Do you have End-Stage Renal Disease (ESRD)? ❑ Yes ❑ No

   If you have had a successful kidney transplant and/or you do not need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

Please complete this section if you have selected a MA-PD plan.

2. 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 a GlobalHealth plan?

   ❑ 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:

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 of Institution (number and street):

City: State: ZIP Code:

Phone Number: – –

4. Are you enrolled in your State Medicaid program? ❑ Yes ❑ No

   If 'yes,' please provide your Medicaid number:

5. Do you or your spouse work? ❑ Yes ❑ No

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

7. Please check the box below if you would prefer us to send you information in another format:

   ❑ Large Print

Please contact GlobalHealth at 1-844-280-5555 (TTY users should call 711) if you need information in another format or language than what is listed above. Our office hours are 8 a.m. to 8 p.m., 7 days a week (October 1 - February 14) and Monday - Friday (February 15 - September 30).

SECTION 5 — STOP Please Read This Important Information STOP

If you currently have health coverage from an employer or union, joining a GlobalHealth MA-PD plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join a GlobalHealth MA-PD 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.

SECTION 6 | Please Read and Sign Below:

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

GlobalHealth 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. (**For Generations Value Plan Only**: 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.

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

Release of Information: By joining this Medicare health plan, I acknowledge that GlobalHealth will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that GlobalHealth 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.

SECTION 6 (cont.) — Please Read and Sign Below:

Signature:

Today's Date: __ __ / __ __ / __ __ __ __

If you are the authorized representative, you must sign above and provide the following information:

Name:

Address:

City: State: ZIP Code:

Phone Number: – –

Relationship to Enrollee: ❑ Child ❑ Friend ❑ Spouse ❑ Other ______________________

Member Material Delivery Preference

I wish to receive my member materials by:

❑ Email (provide email address below)

OR

❑ Mail

If you opt-in to receive your member materials by email, you will NOT receive a copy in the mail unless requested. By opting in for emailed member materials, you will not be subscribing to emails from GlobalHealth.

Office Use Only

Name of staff member/agent/broker (if assisted in enrollment):

Plan ID Number: Effective Date of Coverage: __ __ / __ __ / __ __ __ __

Agent Signature: ____

ICEP/IEP: ❑ AEP: ❑ SEP: ❑
(Type): ______________________

Not Eligible: ❑

Office Use Only, Plan ID Numbers

Generations Value: 1020160

Generations Classic: 1020161

Generations Select: 1020167

GlobalHealth is an HMO plan with a Medicare contract. Enrollment in GlobalHealth depends on contract renewal.