GlobalHealth Medicare Advantage Plans

Short Enrollment Request Form

Name of Plan You are Enrolling In:			
Last Name:	First Name:	MI:	❑ Mr. ❑ Mrs. ❑ Ms.
Member Number:	Home Phone Number:		
Permanent 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:			
City:		State:	ZIP Code:

Please fill out the following:

I am currently a member of the _____ plan in GlobalHealth with a monthly premium of $ _____ .

I would like to change to the _____ plan in GlobalHealth. I understand that this plan has different health benefits and a monthly premium of $ _____.

Name of chosen Primary Care Physician (PCP), clinic or health center:

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

❑ Large Print

Please contact GlobalHealth at [1-844-280-5555] if you need information in another format or language than what is listed above. Our office hours are [8:00 a.m. to 8:00 p.m., 7 days a week (October 1 - February 14) and Monday - Friday (February 15 - September 30).]

Your Plan Premium

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.

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:

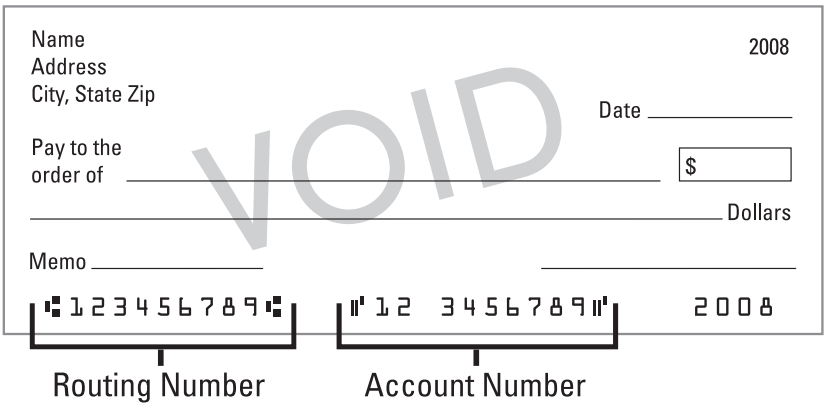
- ❑ Get a Bill
- ❑ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account Holder Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Account Type: ❑ Checking ❑ Saving



- ❑ 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 Read and Sign Below:

GlobalHeath is a plan that has a contract with the Federal government.

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 the Medicare health plan 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 people with Medicare aren't 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 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.

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: _____

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