

# **Enrollment Form**

#### 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 fll 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 monthly Social Security (or Railroad Retirement Board) benefits.

#### What happens next?

Send your completed and signed form to:

By Mail:

GlobalHealth, Inc. P.O. Box 1678 Oklahoma City, OK 73101

By Fax: 405-280-5455 By Email: brokersupport@globalhealth.com

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

## How do I get help with this form?

Call GlobalHealth at 1-844-280-5555.TTY users can call 711.

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

**En español:** Llame a GlobalHealth al 1-844-280-5555/ 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.

## GlobalHealth

Section I - All fields on this page are required (unless marked optional)							
Select the plan you want to join:          Generations Classic Rewards (HMO):          Generations Classic Rewards (HMO):          S0 per month         Generations Valor (HMO-POS)*:          S0 per month         S0 per month         Generations Classic Plus (HMO):          S0 per month         S0 per							
LAST name: FIRST name: (Optional) MI:							
Sex M M D D Y Y Y Y							
Male   Female   Birth Date:   Phone Number:   Image: Control of the second sec							
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.)         Street Number       Street Name         City:       Image: Street Name							
Mailing address, if different from your permanent address: (PO Box allowed)							
Street Number Street Name Lot/Apartment							
City: State: Zip Code: Zip Code:							
E-mail Address (optional):							
I want to get the following materials via email. Select one or more. □ Evidence of Coverage □ Formulary (List of Covered Drugs) □ Provider Directory □ Pharmacy Directory □ Summary of Benefits							
Your Medicare information:							
Medicare Number:							
Answer these important questions:							
Will you have other prescription drug coverage (like VA, TRICARE) in addition to GlobalHealth?       Yes       No         Name of other coverage:       Member number for this coverage:       Group number for this coverage:         Image: Im							
Please choose the NAME of a Primary Care Physician (PCP), Clinic or Health Center:							
FIRST name:							
Are you an existing patient of this PCP? Yes No							
Dual Special Needs Plans Criteria: If you are applying for any one of the following plans, then please provide your Medicaid ID.							
Constraints Dual Support (HMO D SNP)							
Medicaid ID#       Generations Dual Support (HMO D-SNP)         • Generations Dual Premier(HMO D-SNP)							
<ul> <li>Chronic Special Needs Plans Criteria: If you are applying for any one of the following plans, then please fill out 'Chronic Special Needs Plan (SNP) Pre-Qualification Form' attached at the end of this Application Form.</li> <li>Generations Chronic Care (HMO C-SNP)</li> <li>Generations Chronic Care Savings(HMO C-SNP)</li> </ul>							

#### **IMPORTANT:** Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in GlobaHealth.
- By joining this Medicare Advantage Plan, I acknowledge that GlobalHealth 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).
- 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).
- 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 intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that when my GlobalHealth coverage begins, I must get all of my medical and prescription drug benefits from GlobalHealth. Benefits and services provided by GlobalHealth and contained in my GlobalHealth "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor GlobalHealth will pay for benefits or services that are not covered.
- 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:
  - I. 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:			Y Y Y Y
If you're the authorized representative, sign above and fill out these fields:									
LAST name:				FIRST	name:				(Optional) MI:
Permanent Residence Street Address I: (Don't enter a P.O. Box)									
Street Number			Str	reet Name				Lot//	Apartment
City:						State:	Zip	Code:	
Phone Number:					ionship rollee:				

Section 2 - All fields below 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. □ Spanish
Select one if you want us to send you information in an accessible format. Large Print  Audio CD  Braille
Please contact GlobalHealth at 1-844-280-5555 if you need information in an accessible format other than what's listed above. Our office hours are from October 1st to March 31st from 8 a.m. to 8 p.m. 7 days a week and from April 1st to September 30th from 8 a.m. to 8 p.m.

Monday through Friday.TTY users can call 711.

	Do you work?	🗆 Yes	🗆 No	Does your spouse work?	🗆 Yes	🗆 No	
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Are you Hispanic, Latino/a, or Spanish origin? Select all that apply. □ No. Not of Hispanic, Latino/a or Spanish Origin Voc Cuban

$\Box$ ino, not of hispanic,	Latino/a or spanish Origin	🗆 Tes, Cuban
🗋 Yes, Puerto Rican	🛛 Yes, another Hispanic,	Latino or Spanish Or

☐ Yes, Mexican, Mexican American, Chicano/a rigin □ I choose not to answer

What's your race? Select all that apply.

🗆 White 🗆 Black or African American 🗆 American Indian or Alaska Native 🗆 Native Hawaiian 🗆 Samoan 🗔 Other Pacific Island	ler
🗆 Asian Indian 🗇 Chinese 🗅 Filipino 🗅 Japanese 🗋 Korean 🗇 Vietnamese 🖨 Other Asian 🖨 Guamanian or Chamorro	
□ I choose not to answer	

Paying your plan premiums						
You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. 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.						
If you don't select a payment option, you will get a bill each month. If you have to pay a Part D-Income Related Monthly						
Please select a premium payment option:	Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay GlobalHealth the Part D-IRMAA.					
<ul> <li>Get a bill.</li> <li>Automatic deduction from your monthly:</li> <li>Social Security benefit check, or</li> <li>Railroad Retirement Board (RRB) benefit check</li> </ul>						
Did someone other than a sales agent help your complete this form? Complete this section if you're an individual (i.e., SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.						
Name: Relationship to en	rollee:					
Signature:						
OFFICE/AGENT USE ONLY:						
Name of staff member/agent/broker (if assisted in enrollment):	AgentReceived Date:					
Agent Signature:						
Effective Date: (MM/DD/YYYY)       Election Type:       ICEP/IEP       AEP         MA OEP       SEP (type)	e) Discrete the second se					
Agency of Agent:						
Agent Name: (First) (Last)	Agent ID#:					
TR K-I       Referral by Provider       Referred by Member       Company Website       Direct Mail       Self         Local Community Event       Media (TV, News Ad, Mag)       Seminar       Seminar Follow-up						
TR K-2 Personal Appt; Benefit Reply Card (SOA/BRC) UValk-in (SOA) Formal Event (Submit) Application Mailed by Beneficiary Informal Event (SOA)						
Online/Telephonic Application Confirmation #:						
Date Received: Member ID #:						

#### 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.