GlobalHealth
Medicare Advantage Plans

Enrollment Form

GlobalHealth, Inc.
MA-MAPD Individual Enrollment Request 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 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 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: ghmaenrollment@globalhealth.com

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

How do I get help with this form?

Call GlobalHealth at 1-844-200-8167. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a GlobalHealth al 1-844-200-8167/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

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

Select the plan you want to join:

- ❑ Texas LoneStar Gold (HMO): **$0** per month
- ❑ Texas LoneStar Valor (HMO-POS)*: **$0** per month
- ❑ Texas LoneStar Gold Rewards (HMO): **$0** per month
- ❑ Texas LoneStar Chronic Care (HMO C-SNP): **$0** per month
- ❑ Texas LoneStar Chronic Care Savings (HMO C-SNP): **$0** per month
- ❑ Texas LoneStar Dual Support (HMO D-SNP)**: **$0** per month
- ❑ Texas LoneStar Dual Premier (HMO D-SNP)**: **$0** per month

*(MA Only Plan, No Drug Coverage)

**(For QMB and QMB full-benefit dual eligible only)

LAST name: FIRST name: (Optional) MI:

Birth date: M M D D Y Y Y Y

Sex: ❑ Male ❑ Female

Phone number:

Permanent Residence Street Address 1: (Don't enter a PO Box)

Street Number Street Name Lot/Apartment

City: State: Zip Code:

Mailing Address, if different from your permanent address (PO Box allowed):

Street Number Street Name Lot/Apartment

City: State: 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:

Please choose the NAME of a Primary Care Physician (PCP), Clinic or Health Center: **PCP ID Number:**

FIRST name: MI: LAST 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.

Medicaid ID#

- Texas LoneStar Dual Support (HMO D-SNP)
- Texas LoneStar Dual Premier (HMO D-SNP)

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.

- Texas LoneStar Chronic Care (HMO C-SNP)
- Texas LoneStar Chronic Care Savings (HMO C-SNP)

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).
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- 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:
  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:** M M D D 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:

Street Number Street Name Lot/Apartment

City: State: Zip Code:

Phone Number: Relationship to Enrollee:

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 ❑ Braille

Please contact GlobalHealth at 1-844-200-8167 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

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

❑ No, Not of Hispanic, Latino/a or Spanish Origin ❑ Yes, Cuban ❑ Yes, Mexican, Mexican American, Chicano/a

❑ Yes, Puerto Rican ❑ Yes, another Hispanic, Latino or Spanish Origin ❑ **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 Islander

❑ 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.

Please select a premium payment option:

❑ Get a bill.

Automatic deduction from your monthly:

❑ Social Security benefit check, or
❑ Railroad Retirement Board (RRB) benefit check

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. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay GlobalHealth the Part D-IRMAA.

OFFICE USE ONLY:

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

Effective Date: (MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐

Agent Signature: _____ Agent Received Date: ☐☐ ☐☐ ☐☐☐☐

Election Type: ❑ ICEP/IEP ❑ AEP ❑ MA OEP ❑ SEP(type) ☐☐☐☐☐☐☐☐ ❑ Not Eligible

Agency of Agent:_____ Current Insurance:_____

Agent Name: (First) ☐☐☐☐☐☐☐☐☐☐ (Last) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Agent ID#: ☐☐☐☐☐☐☐☐☐☐

TR K-1 ❑ 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) ❑ Walk-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 and 1860D-1 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.

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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: ☐☐/☐☐/☐☐☐☐
- ☐ I was recently released from incarceration. I was released on: ☐☐/☐☐/☐☐☐☐
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on: ☐☐/☐☐/☐☐☐☐
- ☐ I recently obtained lawful presence status in the United States. I got this status on: ☐☐/☐☐/☐☐☐☐
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance or lost Medicaid) on: ☐☐/☐☐/☐☐☐☐
- ☐ 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: ☐☐/☐☐/☐☐☐☐
- ☐ I have both Medicare and Medicaid (or my state helps me pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ 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: ☐☐/☐☐/☐☐☐☐
- ☐ I recently left a PACE program on: ☐☐/☐☐/☐☐☐☐

- [ ] I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on: __ __ / __ __ / __ __ __ __
- [ ] I am leaving employer or union coverage on: __ __ / __ __ / __ __ __ __
- [ ] 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 plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on: __ __ / __ __ / __ __ __ __
- [ ] 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: __ __ / __ __ / __ __ __ __
- [ ] I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- [ ] Other ______________________________

If none of these statements applies to you or you're not sure, please contact GlobalHealth at 1-844-200-8167 (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 - March 31) and 8:00 a.m. to 8:00 p.m., Monday - Friday (April 1- September 30).

AGENT/OFFICE USE ONLY

Last Name: ______________ **First Name:** ______________ **(Optional) MI:** __

Medicare Beneficiary Identifier (MBI): ___________

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Pre-Enrollment Qualification Assessment Tool

Special Needs Plan (SNP) is a type of Medicare Advantage coordinated plan focused on individuals with special needs. Globalhealth offers Special Needs Plans (SNPs) designed for people with certain chronic or disabling conditions.

You may be eligible to join one of our chronic SNPs if you can answer YES to any of the questions below. Globalhealth will need to obtain verification of the chronic condition from your doctor within 30 days of enrollment. We are required to disenroll you from the special needs plan if we are unable to verify your chronic condition. It is very important that you let your doctor know that we will require their verification and that you provide us with accurate contact information for your doctor at the bottom of this form.

Chronic Heart Failure/Cardiovascular Disorder/Diabetes

Has your doctor or other licensed health care professional diagnosed you with any of the following medical conditions?
(Check all that apply)

Chronic Heart Failure (CHF) ☐ Yes ☐ No **Cardiovascular Disorder** ☐ Yes ☐ No

Diabetes Mellitus ☐ Yes ☐ No

Chronic Heart Failure

Do you have fluid in your lungs?
☐ Yes ☐ No

Do you have swelling in your feet and legs almost every day because of too much fluid in your body?
☐ Yes ☐ No

Do you take medicine for the fluid in your lungs or to help your heart beat stronger?
☐ Yes ☐ No

Cardiovascular Disorder

Have you had a heart attack or been told by your doctor you are at risk to have one?
☐ Yes ☐ No

Do you have heart pain (angina) or leg pain (claudication) brought on when you are active?
☐ Yes ☐ No

Do you take medicine for your heart or circulation?
☐ Yes ☐ No

Diabetes

Do you check your blood sugar at home?
☐ Yes ☐ No

Do you have high blood sugar?
☐ Yes ☐ No

Do you take medicine to control your blood sugar?
☐ Yes ☐ No

Beneficiary Information

Beneficiary Name:

Last Name: First Name: (Optional) MI:

Birth Date:
M M / D D / Y Y Y Y

Medicare ID Number (HICN):

I authorize the providers listed below to share my health information with GlobalHealth to verify that I have a chronic condition that qualifies me for enrollment in GlobalHealth's chronic special needs plan. This authorization applies to all health information maintained by the provider concerning my medical history for the chronic condition(s) indicated on the first page. Note: GlobalHealth will protect information disclosed as a result of this authorization in accordance with any state and federal laws and requirements that apply. Call us if you have questions or need help with this form. You can reach us at 1-844-200-8167 (TTY: 711). Hours of operation are 8 a.m. to 8 p.m., seven days a week, (October 1 - March 31), and 8 a.m. to 8 p.m., Monday through Friday, (April 1 - September 30). Visit us at anytime at www.GlobalHealth.com/medicare.

Enrollee Signature:

Today's Date: M M / D D / Y Y Y Y

Name of your Doctor or Health Care Provider:

Last Name: First Name: (Optional) MI:

Phone Number: Fax Phone Number:

(Optional) Name of your Doctor or Health Care Provider:

Last Name: First Name: (Optional) MI:

Phone Number: Fax Phone Number: