# Individual Enrollment Request Form

Samaritan Health Plans

**To enroll in Samaritan Advantage Health Plan (HMO), please provide the following information:**

**Please check which plan you want to enroll in:**

- ❑ Samaritan Advantage Conventional Plan (HMO) $70 per month
- ❑ Samaritan Advantage Premier Plan (HMO) $35 per month
- ❑ Samaritan Advantage Premier Plan Plus (HMO) $129 per month

| First name: | Last name: | Middle initial: |
|---|---|---|
| | | |

| Birth date: (MM/DD/YYYY) | Sex: ❑ M ❑ F | Phone number: |
|---|---|---|
| | | |

Permanent residence street address (Don't enter a PO Box):

| City: | County: | State: | ZIP Code: |
|---|---|---|---|
| | | | |

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

| City: | State: | ZIP Code: |
|---|---|---|
| | | |

**Your Medicare information:**

Medicare Number: ___ ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

**Answer these important questions:**

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Samaritan Advantage Health Plan? ❑ Yes ❑ No

| Name of other coverage: | Member number for this coverage: | Group number for this coverage: |
|---|---|---|
| | | |

# 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) _____ .
- ❑ 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 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 (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.
- ❑ 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) or by the 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 natural disaster.

If none of these statements applies to you or you're not sure, please contact Samaritan Advantage Health Plan at 541-768-4550 or 800-832-4580 (TTY users should call 800-735-2900) to see if you are eligible to enroll. We are open daily 8 a.m. to 8 p.m.

**IMPORTANT: Read and sign below:**

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Samaritan Advantage Health Plan.
- By joining this Medicare Advantage Plan, I acknowledge that Samaritan Advantage Health Plan 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 I 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 Samaritan Advantage Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Samaritan Advantage Health Plan. Benefits and services provided by Samaritan Advantage Health Plan and contained in my Samaritan Advantage Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Samaritan Advantage Health Plan 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: |
|---|---|

**If you're the authorized representative, sign above and fill out these fields:**

| Name: | Address: |
|---|---|
| Phone number: | Relationship to enrollee: |

## Paying Your Plan Premium

**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), credit/debit 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 RRB. DO NOT pay Samaritan Advantage Health Plan the Part D-IRMAA.**

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 800-772-1213. TTY users should call 800-325-0778. You can also apply for Extra Help online at 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 pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

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

**Please select a premium payment option:**

❑ Get a bill monthly.

❑ 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.)

**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.

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.

❑ Braille ❑ Large print ❑ Audio CD

Please contact Samaritan Advantage Health Plan at 541-768-4550 or 800-832-4580 if you need information in an accessible format other than what's listed above. Our office hours are daily from 8 a.m. to 8 p.m. TTY users can call 800-735-2900.

| | |
|---|---|
| Do you work? ❑ Yes ❑ No | Does your spouse work? ❑ Yes ❑ No |

List your Primary Care Physician (PCP), clinic, or health center:

I want to get the following materials via email.

❑ Plan documents

E-mail address:

**Office Use Only:**

Name of staff member/agent/broker
(if assisted in enrollment): _____ Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Samaritan Advantage Health Plan is an HMO with a Medicare contract. Enrollment in Samaritan Advantage Health Plan depends on contract renewal. Samaritan Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-832-4580 (TTY: 1-800-735-2900).