Experience Health Medicare Advantage℠ (HMO)

MedicareRx
Prescription Drug Coverage

Experience Health

P.O. Box 17509
Winston-Salem, NC
27199-3776

2020 Individual Enrollment Form for Experience Health Medicare Advantage (HMO)

Please contact Experience Health if you need information in another language other than English or in an accessible format (Braille).

A. To enroll in Experience Health Medicare Advantage (HMO), please provide the following information:

First Name: Middle Initial:

Last Name: Suffix:

Birth Date: (mm/dd/yyyy) / / Sex: ☐ Male ☐ Female

Primary Phone Number: - -

Alternate Phone Number: (optional) - -

Email Address: (optional)

Permanent Residence Street Address: (P.O. Box is not allowed)

City: State: Zip Code:

County:

Mailing Address: (only if different from your permanent residence address)

City: State: Zip Code:

Emergency Contact: (optional)

Relationship To You: Phone Number: - -

B. 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.

Please note: You must have Medicare Part A and Part B to join a Medicare Advantage Plan.

Name (as it appears on your Medicare card):

Medicare Number: ☐☐☐☐☐☐☐☐☐☐☐

Effective Date: (mm/dd/yyyy)

Hospital (Part A): ☐☐ / ☐☐ / ☐☐☐☐

Medical (Part B): ☐☐ / ☐☐ / ☐☐☐☐

C. Please check which plan you want to enroll in:

☐ **Experience Health Medicare Advantage (HMO)** (H3777-001-002)**: $20.00 per month**
Available in 2 counties:

Durham
Person

☐ **Experience Health Medicare Advantage (HMO)** (H3777-001-003)**: $20.00 per month**
Available in 4 counties:

Granville
Lee
Orange
Vance

☐ **Experience Health Medicare Advantage (HMO)** (H3777-001-004)**: $20.00 per month**
Available in 2 counties:

Franklin
Wake

D. Please choose the name of a Primary Care Provider (PCP):

Name of Primary Care Provider: If you do not choose a PCP, one will be assigned to you.

Provider Address:

City: State: Zip Code:

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PCP Code: (National Provider Identifier #)

PCP Phone:

(To find a PCP code, go online to ***ExperienceHealthNC.com***)

☐ Current patient

☐ New patient

E. Paying your plan premium:

Zero Premium Plans: 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 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.

Plans with 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 automatic deduction from your Social Security or RRB benefit check each month.

Zero Premium and Plans with premiums: If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), 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 Experience Health 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 coinsurance. 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 ***ssa.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 the 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. **You must continue to pay your Medicare Part B premium.**

Please select a premium payment option:

☐ Get a bill each month.

☐ Automatic deduction from your monthly Social Security benefit check.

☐ Automatic deduction from your monthly Railroad Retirement Board (RRB) benefit check.

Please note: 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.

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F. Please read and answer these important questions:

☐ Yes
☐ No

1. Do you have End Stage Renal Disease (ESRD)? If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **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.

☐ Yes
☐ No

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 Experience Health Medicare Advantage (HMO)? **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: _____

☐ Yes
☐ No

3. Are you enrolled in your state Medicaid program? **If "yes,"** please provide your Medicaid number.

Medicaid number: ☐☐☐☐☐☐☐☐☐☐☐

G. Please read this important information:

If you currently have health coverage from an employer or union, joining Experience Health Medicare Advantage (HMO) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Experience Health Medicare Advantage (HMO). 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.

H. 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 on the left 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.

☐ Annual Enrollment Period (AEP). Your plan effective date will be **January 1**.

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☐ 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 the service area for my current plan **or** I recently moved and this plan is a new option for me.

Where are you moving from:

County: _____ State: _____

I moved on: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

Choose your plan's effective date: (mm/dd/yyyy)
☐☐ / 0 1 / ☐☐☐☐

☐ 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 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 or live in a Long-Term Care Facility. (For example, a nursing home or long-term care facility.)

I moved/will move into facility on: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

☐ I recently moved out of a Long-Term Care Facility. (For example, a nursing home or long-term care facility.)

I moved/will move out of facility on: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

☐ I recently left a PACE program on: (Programs of All-Inclusive Care for the Elderly)

I recently left a PACE program on: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

☐ I recently involuntarily lost my creditable prescription drug coverage. (Coverage as good as Medicare's)

I lost my drug coverage on: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

Choose your plan's effective date: (mm/dd/yyyy)
☐☐ / 0 1 / ☐☐☐☐

Continued ▶

☐ I am leaving employer or union coverage on:

(mm/dd/yyyy)

☐☐ / ☐☐ / ☐☐☐☐

Choose your plan's effective date: (mm/dd/yyyy)

☐☐ / 0 1 / ☐☐☐☐

☐ I belong to a pharmacy assistance program provided by my state.

☐ 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)

☐☐ / ☐☐ / ☐☐☐☐

Choose your plan's effective date: (mm/dd/yyyy)

☐☐ / 0 1 / ☐☐☐☐

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

My plan is ending on: (mm/dd/yyyy)

☐☐ / ☐☐ / ☐☐☐☐

My plan is with:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐ 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 an SNP on: (mm/dd/yyyy)

☐☐ / ☐☐ / ☐☐☐☐

Choose your plan's effective date: (mm/dd/yyyy)

☐☐ / 0 1 / ☐☐☐☐

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

☐ None of these statements apply to me.*

Other Special Enrollment Period (SEP) reason:

_____

_____

* To see if you are eligible to enroll, please contact **Experience Health Medicare Advantage (HMO)** at: **1-833-905-1298** or, for TTY users, Dial **711**, 7 days a week, 8 a.m. to 8 p.m. between October 1 – March 31; 8 a.m. to 8 p.m. Monday – Friday between April 1 – September 30.

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I. Applicant Agreement:

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,** this signature certifies that: 1) this person is authorized under state law to complete this enrollment form; and 2) documentation of this authority is available upon request from Medicare.

Your Signature: _____ / / Today's Date: (mm/dd/yyyy)

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:

If you prefer us to send you information in a language other than English or in another format (e.g., Braille, audio tape or large print), please contact **Experience Health Medicare Advantage (HMO)**, at **1-833-777-7394** or, for TTY users, **1-833-397-4584**, 7 days a week, 8 a.m. to 8 p.m. between October 1 – December 31; 8 a.m. to 6 p.m. Monday – Thursday and 8 a.m. to 5 p.m. on Fridays between January 1 – September 30.

LICENSED AGENT USE ONLY

Agents must submit a signed enrollment form within 24 hours of receipt.

Agent's Signature: _____

Print Agent's Name: _____

Date Application Received: / / (mm/dd/yyyy)

Phone Number: _____ NPN#: (required) _____

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Statement of Understanding

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

1. Experience Health is an HMO plan with a Medicare contract. Enrollment in Experience Health depends on contract renewal. 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.
2. It is my responsibility to inform Experience Health of any prescription drug coverage that I have or may get in the future.
3. I understand that if I do not 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.
4. 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.
5. Experience Health serves a specific service area. If I move out of the area that Experience Health serves, I need to notify the plan so I can disenroll and find a new plan in my new area.
6. Once I am a member of Experience Health, I have the right to appeal plan decisions about payment or services if I disagree.
7. I will read the Evidence of Coverage from Experience Health when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.
8. 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.
9. I understand that beginning on the date Experience Health Medicare Advantage (HMO) coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Experience Health provides refunds for all covered benefits, even if I get services out-of-network.
10. Services authorized by Experience Health Medicare Advantage (HMO) and other services contained in my Experience Health Medicare Advantage (HMO) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR EXPERIENCE HEALTH MEDICARE ADVANTAGE (HMO) WILL PAY FOR THE SERVICES.
11. I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Experience Health, he/she may be paid based on my enrollment in Experience Health.
12. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information

1. By joining this Medicare health plan, I acknowledge that Experience Health will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.
2. I also acknowledge that Experience Health 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.
3. 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.