OMB No. 0938-1378 Expires: 7/31/2023

# Individual Enrollment Form

Devoted HEALTH PLANS

## 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) benefit.

## What happens next?

Send your completed and signed form to:

**Mail**
Devoted Health – Enrollment
PO Box 211157
Eagan, MN 55121

**Fax**
1-833-434-0535

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

## How do I get help with this form?

Call Devoted Health at **1-800-385-0916** (TTY 711). Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

**En español:** Llame a Devoted Health al 1-800-385-0916 (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.

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-NEW. 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.

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# Section 1

All fields on this page and the next page are required (unless marked optional).

Devoted HEALTH PLANS

## FILL IN THE PLAN YOU WANT TO JOIN

**Plan Name** (located on the front cover of Summary of Benefits):

**Plan Benefit Package (PBP) Number:** H _ _ _ _ - _ _ _

**County:**

**First Name:**

**Last Name:**

**Middle Initial** (optional):

**Preferred First Name** (optional):

**Birth Date:** _ _ / _ _ / _ _ _ _

☐ Male ☐ Female

**Provide your cell phone number below if you wish to receive text messages**

**Home Phone Number:**

**Cell Phone Number*** (optional):

**Email Address** (optional):

**Permanent Residence Street Address** (don't enter a PO Box):

**City:**

**State:**

**Zip:**

**Mailing Address, if Different From Your Permanent Address** (PO Box allowed):

**City:**

**State:**

**Zip:**

## YOUR MEDICARE INFORMATION

**Medicare Number:** _ _ _ _ - _ _ _ - _ _ _ _

*By providing my cell phone number, I consent to receiving text messages regarding my plan and care from Devoted Health and its related medical practices. Msg frequency varies. Msg&data rates may apply. Reply STOP to cancel messages and HELP for help. devoted.com/terms-of-use and devoted.com/privacy-policy

## LET'S CHECK IF YOU CAN JOIN A PLAN RIGHT NOW

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 recently was 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 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 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 natural disaster. (Be sure to check the other statement that applied to you).

If none of these statements applies to you or you're not sure, please contact Devoted Health at **1-800-385-0916** (TTY 711) to see if you are eligible to enroll. We are open 8am to 8pm, Monday to Friday (from October 1 to March 31, 8am to 8pm, 7 days a week).

## ANSWER THESE IMPORTANT QUESTIONS

**Are you a veteran?** ☐ Yes ☐ No

**Will you have other prescription drug coverage (like VA, TRICARE) in addition to your Devoted Health plan?** ☐ Yes ☐ No

**Name of other coverage:**

**Member number for this coverage:**

**Group number for this coverage:**

**Are you enrolled in your state Medicaid program?** ☐ Yes ☐ No

**If Yes, Your Medicaid Number:**

## IMPORTANT: READ AND SIGN BELOW

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

# Section 2

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Devoted HEALTH PLANS

**Do you need materials from us in Spanish?**

☐ Yes ☐ No

**Which accessible format do you need?** (choose only one)

☐ None ☐ Braille ☐ Audio Tape ☐ Large Print

Please contact Devoted Health at **1-800-385-0916** (TTY 711) if you need information in an accessible format other than what's listed above. Our office hours are 8am to 8pm, Monday to Friday (from October 1 to March 31, 8am to 8pm, 7 days a week).

**Do you work?** ☐ Yes ☐ No **Does your spouse work?** ☐ Yes ☐ No ☐ N/A

**Primary Care Provider (PCP):** This is the main doctor you see for your care. To make for the easiest start with your new plan, please tell us about your PCP. If you leave this section blank, we'll choose a PCP for you.

**Full Name:**

**Address:**

**Are you a patient there now?** ☐ Yes ☐ No

## 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 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 Devoted Health the Part D-IRMAA.

**How would you like to pay?** Choose only one. If you don't select an option below, we'll send a monthly bill.

☐ **Send me a monthly bill**

☐ **Take it out of my monthly Social Security check***

☐ **Take it out of my monthly Railroad Retirement Board (RRB) check***

*May take at least 2 months to start. The first deduction usually includes all premiums due up to that point.

**PRIVACY ACT STATEMENT** The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

**FOR LICENSED SALES REPRESENTATIVE / AGENCY USE ONLY**

☐ New Member ☐ Plan Change

| | |
|---|---|
| **Licensed Sales Agent Full Name:** | **Initial Receipt Date:** |
| **Licensed Sales Agent NPN:** | **Proposed Effective Date:** |
| **Licensed Sales Agent Phone:** | |

**Method of Contact:**

☐ Agent Generated ☐ Marketing Campaign
☐ Sales Seminar ☐ Referral
☐ Community Event

**Select Enrollment Period:**

☐ AEP ☐ SEP (Losing Coverage) ☐ SEP (Moved Coverage Area)
☐ MA OEP ☐ SEP (Dual Eligible) ☐ SEP (Non-Renewal)
☐ ICEP (MA Enrollees) ☐ SEP (LIS) ☐ SEP (Other)
☐ IEP (MA-PD Enrollees) ☐ OEPI

| | |
|---|---|
| **SEP Reason:** | **SEP Eligibility Date:** |

**Licensed Sales Rep Signature (Required):**

**Please send your completed form to:**

**Mail**
Devoted Health – Enrollment
PO Box 211157
Eagan, MN 55121

**Fax**
1-833-434-0535

Devoted Health is an HMO and PPO plan with a Medicare contract. Our D-SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.