Priority Health

Medicare enrollment form

MAPD Plans

Thank you for choosing a Medicare plan from Priority Health.

Please follow these helpful tips to avoid delays in processing your enrollment.

To enroll online visit ***prioritymedicare.com***. The Provider/Pharmacy Directory, Evidence of Coverage and Formulary are also available here.

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)
- Reminder: 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.
- 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.

Enrollment Form checklist

- ☐ Choose an enrollment eligibility selection that applies to you on the third page.
- ☐ Check the appropriate box for the plan you wish to join.
- ☐ Choose a primary care provider (PCP), if applicable.
  To confirm that your doctor, clinic or health center is part of the Priority Health Medicare network of providers, go to ***priorityhealth.com/findadoc*** or call our Medicare Experts at the phone number listed on the second page.
- ☐ Complete your Medicare Insurance information from your Medicare red, white and blue card or attach a photocopy of your Medicare card as proof that you have Medicare Parts A and B coverage.
- ☐ Choose how you would like to pay your premium and check the appropriate box.
  There are three options available for paying your plan premium. You can choose to receive a monthly bill and pay by mail, Electronic Fund Transfer (EFT) from your bank account or automatic deduction from your monthly Social Security check.
- ☐ Sign and date the form.

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Mail your completed enrollment form in the enclosed postage-paid envelope. Or, if you do not have a postage-paid envelope, you can send your completed enrollment form to Priority Health, MS 1175, 1231 E. Beltline, Grand Rapids, MI 49525. You may also scan the completed form and email it to ***PH-MedicareEnrollment@priorityhealth.com***.

If you have any questions or you would prefer that we send you information in another format, such as large print or Braille, call our Medicare experts toll-free at 877.230.1560, from 8 a.m. – 8 p.m., seven days a week. TTY users should 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 Priority Health at 877.230.1560. 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.

For 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.

Medicare Enrollment Request Form

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 for the statement that 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.

Choose one of the following:

☐ I am new to Medicare (example: recently enrolled in Medicare Parts A and B).

☐ I had Medicare prior to now, but I am now turning 65.

☐ I am electing to enroll during the annual enrollment period (Oct. 15 through Dec. 7).

☐ I am enrolled in a Medicare Advantage plan and want to make a one-time change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I am leaving or recently lost employer or union coverage on (insert date) (MM/DD/YYYY)____/_____/_____ (example: retiring and losing coverage through an employer).

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost or will lose this drug coverage on (insert date)____/_____/_____.

☐ 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 recently had a change in my Medicaid coverage on (insert date) ____/_____/_____ (example: new to Medicaid, had a change in level of Medicaid assistance, or lost Medicaid).

☐ I recently had a change in my extra help paying for Medicare prescription drug coverage on (insert date) ____/_____/_____ (example: new to extra help, had a change in the level of extra help, or lost extra help).

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

☐ I was enrolled in a Special Needs Plan (SNP) but I recently lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date)____/_____/_____.

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

☐ I recently left a PACE program on (insert date) ____/_____/_____.

☐ 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 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 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 received this status on (insert date)____/_____/_____.

☐ I recently was released from incarceration. I was released on (insert date) ____/_____/_____.

If none of these statements apply to you or you're not sure, please contact Priority Health Medicare to see if you are eligible to enroll. Call toll-free 877.230.1560 (TTY users should call 711), 8 a.m. – 8 p.m., seven days a week.

To enroll in Priority Health Medicare, please provide the following information

Check which plan you want to enroll in:

Available in regions 1, 2 and 5

☐ **Priority**Medicare℠ Edge (PPO), $0 per month

☐ **Priority**Medicare℠ Vintage (HMO-POS), $0 per month

☐ **Priority**Medicare℠ Vital (PPO), $0 per month

Available in all Lower Peninsula counties

☐ **Priority**Medicare℠ Key (HMO-POS), $0 per month

☐ **Priority**Medicare℠ (HMO-POS)		☐ **Priority**Medicare℠ Value (HMO-POS)		☐ **Priority**Medicare℠ Merit (PPO)	
Region 1	$70 per month	Region 1	$18 per month	Region 1	$59 per month
Region 2	$75 per month	Region 2	$32 per month	Region 2	$72 per month
Region 3	$109 per month	Region 3	$69 per month	Region 3	$104 per month
Region 4	$99 per month	Region 4	$44 per month	Region 4	$118 per month
Region 5	$55 per month	Region 5	$32 per month	Region 5	$95 per month

See the Summary of Benefits for a listing of counties in each region.

Optional coverage

Do you want to enroll in, or continue your current enrollment in the **Enhanced Dental and Vision package**? ☐ Yes ☐ No

This package is offered in addition to the standard dental and vision benefit that's included in our plans. You're not required to enroll in the Enhanced Dental and Vision package. You may also choose to add this coverage anytime within two months from your Priority Health Medicare Advantage plan effective date. For **Priority**Medicare℠ Edge, **Priority**Medicare℠ Merit, **Priority**Medicare℠, or **Priority**Medicare℠ Vintage plans, it's an additional monthly premium of $49. For the **Priority**Medicare℠ Key and **Priority**Medicare℠ Vital plans, it's an additional monthly premium of $39. For the **Priority**Medicare℠ Value plan, it's an additional monthly premium of $37.

Last name	First name	M.I. (optional)

Birth date ____/____/_____ MM DD YYYY	Sex ☐ M ☐ F	Phone number that we may use to contact you: ( ) ☐ Landline (home phone) ☐ Mobile phone	Alternate number that we may use to contact you (optional): ( ) ☐ Landline (home phone) ☐ Mobile phone

Permanent residence street address (P.O. Box is not allowed unless you're an individual experiencing experiencing homelessness)

City	County	State	ZIP code

Mailing street address (only if different from your permanent residence address)

City	County	State	ZIP code

Email address (optional)

Check the box below to opt-in to receiving certain plan documents by email.

☐ Annual Notice of Change document

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Priority Health Medicare? ☐ Yes ☐ No

Name of other coverage	Member number for this coverage	Group number for this coverage

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.	Name (as it appears on your Medicare card): Medicare Number: _____ Is entitled to: Effective date: **HOSPITAL (Part A)** ____/____/____ **MEDICAL (Part B)** ____/____/____ You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Paying your plan premium

You can pay your monthly plan premium, if there is one, (including any late enrollment penalty that you may have or may owe) by mail or electronic funds transfer (EFT) 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 (D-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 or Railroad Retirement Board benefit check or be billed directly by Medicare or RRB. Do NOT pay Priority Health the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. 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 don't select a payment option, you will get a bill each month.

Please choose one premium payment option:

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.**
I receive monthly benefits from: ☐ Social Security ☐ RRB

The Social Security/RRB deduction may take up to three months to begin once Social Security or RRB approves the deduction. Depending on when this is approved, you may receive a mailed invoice. In most cases, when 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 the deduction date listed above. If Social Security or RRB does not approve your request for Social Security deduction, we'll send you a monthly invoice for your monthly premiums. Should you disenroll from this plan, Social Security will refund your premium within three benefit checks of your disenrollment date.

☐ **Electronic funds transfer (EFT) automatically from your bank account each month.** Fill out the EFT section below.

On the first business day of every month, the checking or savings account you designate will be debited for the total amount of your outstanding premium(s).

Your first draft may be for two months' payments. If your bank account does not have sufficient funds to cover your plan's premium payment, Priority Health reserves the right to charge a non-sufficient funds (NSF) fee up to the amount allowed by the state of Michigan, which is $25. A second NSF return may result in termination of coverage or loss of EFT privileges.

Please note, with Social Security deduction and EFT you will not receive a monthly invoice. If you wish to request a monthly information only statement, please contact customer service at 888.389.6648.

☐ **Get a bill monthly and pay the plan directly by mail or phone.**

EFT Information

Account holder's name (print)	Account type ☐ Checking ☐ Savings
Name of financial institution	Bank account number
Bank routing number (9 digits on the bottom of the check for a checking account) or attach a copy of a voided check *(do not use a deposit slip)*	
Account holder's signature	Date

Additional questions

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

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

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ I choose not to answer.

What is your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ I choose not to answer.

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

Do you work? ☐ Yes ☐ No Does your spouse (if applicable) work? ☐ Yes ☐ No

Please check one of the boxes below if you would prefer that we send you information in a language other than English or an accessible format: ☐ Spanish ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Priority Health at 888.389.6648 (TTY 711), from 8 a.m. to 8 p.m., seven days a week, if you need information in an accessible format other than what's listed above.

STOP! Please read this important information

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

Please read and sign below

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

- Priority Health Medicare plans are Medicare Advantage plans and have a contract with the federal government. 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 Advantage health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire calendar 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: Oct. 15 - Dec. 7 of every year) or under certain special circumstances.

- Priority Health Medicare serves a specific service area. If I move out of the area that Priority Health Medicare serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Priority Health Medicare, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Priority Health Medicare when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that Priority Health Medicare provides coverage for me in the United States and around the world for emergency and urgent care.

- I understand that if Priority Health has not received my plan premium by the first of the month, they will send a notice letting me know that my membership in the Medicare Advantage plan and/or Enhanced Dental and Vision package (if applicable), may end if they do not receive my premium payment in full, within 90 calendar days.

- For **Priority**Medicare℠ Edge, **Priority**Medicare℠ Key, **Priority**Medicare℠, **Priority**Medicare℠ Merit, **Priority**Medicare℠ Value, **Priority**Medicare℠ Vintage and **Priority**Medicare℠ Vital plan enrollees: I understand that when my Priority Health Medicare coverage begins, I must get all of my medical and prescription drug benefits from Priority Health. Benefits and services provided by Priority Health and contained in my Priority Health "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Priority Health will pay for benefits or services that are not covered.

- **For Optional Enhanced Dental and Vision package enrollees**, I understand that the dental and vision services included in this package are offered through vendors contracted with Priority Health Medicare. Benefit/coverage details, the amount you pay when using participating and non-participating providers, limits/exclusions, etc. can be found in the Evidence of Coverage document. The dental benefit is offered through Delta Dental. In-network benefits apply to services provided by a Delta Dental Medicare Advantage PPO or Medicare Advantage Premier participating dentist, in Michigan, Ohio or Indiana. All other dentists are considered out-of-network (nonparticipating) dentists. If the Dentist you select is not a Delta Dental Medicare Advantage Participating Dentist, you will still be covered, but you may have to pay more. The vision benefit is offered through EyeMed. In-network benefits apply to services provided by an EyeMed participating provider. Services provided by non-participating EyeMed providers are reimbursable up to a set dollar amount. Enrollment in this plan is generally for the entire calendar year. Although, I may leave this plan at any time. Please contact us or refer to your EOC (Chapter 4, Section 2.2) for instructions on how to disenroll.

- I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Priority Health Medicare, he/she may be paid based on my enrollment in Priority Health Medicare.

- **Release of Information:** By joining this Medicare health plan, I acknowledge that Priority Health Medicare will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Priority Health Medicare 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. 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 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 (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 from Medicare.

Signature	Today's date __ __ / __ __ / __ __ __ __

A paper form can only be accepted with a handwritten signature. Electronic, digital or typed signatures are not permitted per the Centers for Medicare and Medicaid services.

If you are the authorized representative, sign above and complete the following fields:

Name: _____

Street address: _____

City: _____ State: _____ ZIP: _____

Phone number: (_____) _____- _____

Relationship to Enrollee:
☐ Power of attorney
☐ Legal Guardian
☐ Conservator

To help keep our records up-to-date and/or if additional actions need to take place on behalf of the member once enrolled, you may provide documentation to help verify legal guardianship agreements. Please scan and email or mail legal documents to: Priority Health, MS 1115, 1231 E. Beltline Ave NE, Grand Rapids, MI 49525 or email *MedicareCS@priorityhealth.com*. You may also create a member account and send the documentation via secure message.

For individuals and agents helping enrollee with completing this form only:
Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee:_____

Signature: _____

Agent information

Referring agent number: _____

Referring agent National Producer Number: _____

Field Market Organization (FMO) name *(if applicable)*:

_____

Agent received application on:

_____/_____/_____

FMO received application on *(if applicable)*:

_____/_____/_____

Scope of Appointment completed: ☐ Yes (Date completed: _____/_____/_____)
☐ No (Reason: _____)

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.

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 the "Enrollment form checklist" on the first and second pages to send your completed form to the plan.

PRA Disclosure Statement
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 collection is 0938-1378. The time required to complete this information collection is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, and 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.

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