OMB No. 0938-1378
Expires:7/31/2024

SUMMIT HEALTH

Summit Health Medicare Advantage Plans

Individual enrollment election 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 unless labeled as optional. If an item is labeled optional, you cannot be denied coverage for not filling it 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 bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?
Send your completed and signed form to:
Summit Health Plan, Inc.
Attn: Medicare Membership Accounting
601 SW 2nd Ave
Portland, OR 97204-9748

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

How do I get help with this form?
Call Summit Health Medicare Advantage at 844-931-1782. 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 Summit Health Medicare Advantage al 844-931-1782/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.

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.

Summit Health Medicare Advantage Plans

Individual enrollment election form

Summit Health Plan, Inc.
Attn: Medicare Membership Accounting
601 SW 2nd Ave | Portland, OR 97204-9748

541-663-2721 | 844-827-2355
TTY: 711 | Fax: 833-949-1891

To enroll in a Summit Health Medicare Advantage plan, please provide the following information:

Please check which plan you want to enroll in:

☐ Summit Health Core (HMO-POS) $19.00 per month H2765-001 *This plan **does not include** Part D prescription drug coverage*	☐ Summit Health Value + Rx (HMO) $59.00 per month H2765-002	☐ Summit Health Standard + Rx (HMO-POS) $89.00 per month H2765-003	☐ Summit Health Premier + Rx (HMO-POS) $139.00 per month H2765-004

Last name	First name	Middle initial (optional)	
Birth date (mm/dd/yyyy) _____ / _____ / _____	Sex ☐ M ☐ F	Home phone number (_____) _____	Alternate telephone number (optional) (_____) _____
Permanent residence street address (P.O. Box is not allowed)			
City	County (optional)	State	ZIP code
Mailing address (only if different from your permanent residence address)			
Street address			
City		State	ZIP code
Email address (optional):			

Please provide your Medicare insurance information

Medicare Number: _ _ _ _-_ _ _-_ _ _ _
Hospital Part A effective date (optional): _____
Medical Part B effective date (optional): _____
Prescription Part D effective date (optional): _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

How to pay your plan premium (Optional. You can decide now or later.)

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, eBill or "Electronic Funds Transfer" (EFT) 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 Summit Health Plan, Inc. the Part D-IRMAA.

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

Please select a premium payment option:

☐ Get a monthly bill	☐ 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 ☐ Savings
☐ eBill, online premium payment *eBill is an online premium payment tool. When you receive your Summit Health member ID number, visit yoursummithealth.com and create your Member Dashboard. Once your Member Dashboard is created, click on the eBill tab to view and pay your monthly premium.*	☐ 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. How premium is collected for months prior to the start of withholding depends on when your application is received and the effective date of enrollment. In some cases, Social Security/ RRB deducts for those months once withholding begins. It's important to note that this means premium for multiple months may be deducted from a single benefit check. In other cases, you will receive paper bills and be responsible to pay us directly for months prior to the start of withholding. If Social Security or RRB does not approve your request for automatic deduction, we will send you paper bills for your monthly premiums on an ongoing basis.)*

Please read and answer these important questions:

1. Some individuals may have other coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State pharmaceutical assistance programs. Will you have other coverage in addition to a Summit Health Medicare Advantage plan?
   ☐ Yes ☐ No *If "yes," please list your other coverage and your identification (ID) number(s) for this coverage.*

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

   Check all that apply:
   ☐ Medical ☐ Prescription
   ☐ Dental ☐ Vision

2. Are you enrolled in your State Medicaid program (optional)? ☐ Yes ☐ No

   If "yes," please provide your Medicaid number: _____

3. Do you or your spouse work (optional)? ☐ Yes ☐ No

Please choose the name of a Primary Care Provider (PCP), clinic or health center (optional):

_____

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

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

What's your race? Select all that apply. (optional):

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

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format (optional): ☐ LARGE PRINT ☐ Spanish ☐ Braille ☐ Audio CD

Please contact Summit Health Medicare Advantage at 844-827-2355 if you need information in an accessible format or language other than what is listed above. Customer Service is available from 7 a.m. to 8 p.m., Pacific Time, seven days a week from Oct 1 through March 31, with the exception of Thanksgiving Day and Christmas Day. (After March 31, your call will be handled by our automated phone system Saturdays, Sundays and holidays.)

IMPORTANT: Please read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in a Summit Health Medicare Advantage Plan.
- By joining this Medicare Advantage Plan, I acknowledge that Summit Health Medicare Advantage 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.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- 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 when my Summit Health Medicare Advantage coverage begins, I must get all of my medical and prescription drug benefits from Summit Health Medicare Advantage. Benefits and services provided by Summit Health Medicare Advantage and contained in my Summit Health Medicare Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Summit Health Medicare Advantage 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 are the authorized representative, sign above and provide the following information:

Name: _____

Address: _____

Phone number: (_____) _____ Relationship to enrollee: _____

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: _____

If you are an agent contracted with Summit Health Plan, Inc. you must provide the following,

Agency: _____ Date enrollment form received by agent: _____ / _____ / _____

Telephonic enrollment intake by:

_____

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 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.

SUMMIT HEALTH

Summit Health Medicare Advantage

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 am enrolling during the Annual Election Period (AEP), which takes place from October 15 to December 7 of each year.
- ☐ 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 effective date of change) _____ / _____ / _____ .
- ☐ 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 on (insert date) _____ / _____ / _____ .
- ☐ Medicare is ending its contract with my plan 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 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 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.

If none of these statements applies to you or you're not sure, please contact Summit Health Medicare Advantage at 844-827-2355 (TTY users should call 711) to see if you are eligible to enroll.