Health Alliance™

Medicare Advantage Enrollment Request Form – Illinois and Western Indiana HMO and POS Plans

January 1, 2021 – December 31, 2021

2021

Toll-free 1-888-382-9771 (TTY 711)
Fax 217-902-9785
HealthAllianceMedicare.org

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 January1)
- 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 bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Health Alliance Medicare
Application Processing Center
3310 Fields South Drive
Champaign, IL 61822

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

How do I get help with this form?

Call Health Alliance Medicare at (888) 382-9771 (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 Health Alliance al o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Health Alliance Medicare is a Medicare Advantage Organization with a Medicare contract. Enrollment in Health Alliance Medicare depends on contract renewal.

1-888-382-9771 (TTY 711)
Fax 217-902-9785
HealthAllianceMedicare.org

Health Alliance™

1-888-382-9771

3310 Fields South Drive, Champaign, IL 61822

MEDICARE ADVANTAGE ENROLLMENT REQUEST FORM

Agent/Office Staff Use Only:

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

Date Received: _____ Effective Date of Coverage: _____ NPN: _____

Check one: ❑ ICEP/IEP ❑ AEP ❑ SEP/OEP (attestation form must be included if SEP is checked)

Marketing Meeting Date: _____

Please contact Health Reid Health Alliance Medicare if you need information in another language or format (Braille).

Section 1 - All fields on this page are required (unless marked optional)

Select the plan you want to join:

❑ POS Basic (HMO-POS)	$23 per month	❑ HMO Basic (HMO)	$0 per month
❑ POS Basic Rx (HMO-POS)	$51 per month	❑ HMO Basic Rx (HMO)	$32 per month
❑ POS 30 Rx (HMO-POS)	$105 per month	❑ HMO 40 Rx (HMO)	$73 per month
❑ POS 10 Rx (HMO-POS)	$165 per month	❑ HMO 20 Rx (HMO)	$120 per month

FIRST name: LAST name: Optional: Middle Initial:

Birth Date:	Sex:	Phone Number:
(__ __ / __ __ / __ __ __ __) M M D D Y Y Y Y	❑ Male ❑ Female	( ) -

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

_____

City: _____ Optional: County: _____ State: _____ ZIP Code: _____

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

Street Address: _____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 Health Alliance Medicare?
❑ Yes ❑ No

Name of other coverage: _____

Member number for this coverage: _____

Group number for this coverage: _____

IMPORTANT: Read and sign below:

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

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number (_____) _____ - _____

Relationship to Enrollee: _____

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 Health Alliance Medicare at (888) 382-9771 if you need information in an accessible format or language other than what is listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. TTY users should call 711. Voicemail is used on holidays and weekends from April 1 to September 30.

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. Select one or more.
❑ Using your coverage
❑ Information and updates about your plan

E-mail address: _____

Paying your plan premiums

You can pay your monthly plan premium by mail, "Electronic Funds Transfer (EFT)", or credit card 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 Health Alliance Medicare the Part D-IRMAA.

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.