



Enrollment Form

FOLLOW THESE EASY STEPS TO BECOME A HEALTHSUN HEALTH PLAN MEMBER

I. HAVE YOUR MEDICARE CARD READY

Please print legibly and complete the entire form. You will need to fill in the information exactly as it appears on your Medicare Card. Each person must complete a separate form.

II. UNDERSTANDING YOUR PLAN

Be sure you read each section carefully and that you understand the information.

III. SIGN AND DATE THE ENROLLMENT FORM

If someone assisted you in completing the form (other than your plan representatives), he/she will also need to sign.

IV. Keep Member Copy for your Records

Proposed Effective Date: _____

To Enroll in HealthSun Health Plans, Inc., Please Provide the Following Information:

Please check which plan you want to enroll in:

Sun Plus Advantage 001 Sun Plus Advantage 002 Healthy Advantage 005 MediMax 006

Medicare Health Insurance Social Security Act		
_____ <input type="checkbox"/> M <input type="checkbox"/> F		
Beneficiary Last Name,	First Name	Initial
Medicare Claim Number (HICN Number)		

Is Entitled to:		
_____ Hospital Insurance Part A	Effective date: _____	
_____ Medical Insurance Part B	Effective date: _____	

Please take out your Medicare card to complete this section.

Please fill in these blanks so they match your red, white and blue Medicare card, or Attach a copy of your Medicare Card or your letter from Social Security or the Railroad Retirement Board.

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

PLEASE PRINT

Name: _____
Last Name First Name MI

Permanent Address (street number, floor) _____

City: _____ County: _____ State: _____ Zip Code: _____

Mailing Address (if different than your permanent address): _____

City: _____ County: _____ State: _____ Zip Code : _____

Telephone: () _____ E-mail address (optional): _____

Date of Birth: _____ Please check box if you prefer information in a language other than English . Please contact HealthSun at (305) 234-9292 if you need information in another format or language than what is listed above our office hours are Monday through Friday 8:30am to 8:30pm. TTY users should call (877)206-0500.

Name of Emergency Contact : _____

Telephone Number: () _____ Relationship to you: _____

Select from the Provider Directory the following:

Name of Primary Care Physician: _____ Provider Number: _____

Is this your current physician? Yes No

Name of Dentist: _____ Provider Number: _____

PAYING YOUR PLAN PREMIUM: If we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail or Electronic Funds Transfer (EFT) each month or quarterly. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month. People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% of drug costs including who monthly prescription drug premiums, annual deductibles, and co-insurance. 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 www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medical will pay all or part of your plan premium. If Medicare pays only a portion of this 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.

Please select a premium payment option:

Receive a Bill Automatic deduction from your monthly Social Security Benefit check (the Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security Benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.) Electronic funds transfer (EFT) from your bank account each month. Please provide a VOIDED check or provide the following: Checking Savings

RELEASE OF INFORMATION: By joining Medicare Health Plan, I acknowledge that HealthSun Health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that HealthSun 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 by HealthSun Health Plans or by Medicare.

PRINT YOUR NAME _____ **TODAYS DATE:** _____

YOUR SIGNATURE: _____

If you are the authorized representative you must provide the following information:

Name: _____

Address: _____

Phone Number: _____ **Relationship to enrollee:** _____

ELECTION PERIOD STATEMENTS

Typically, you may enroll in a Medicare Advantage plan during the Annual Enrollment Period (AEP) between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the Open Enrollment Period (OEP) between January 1 and March 31 of each year, as long as you don't add or drop your prescription drug coverage. Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these election periods. Please read the following statements carefully and please check the box if the statement(s) 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 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 _____.(please insert date).
- I recently moved and this plan is a new option for me.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- 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 _____(please 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 _____ (please insert date).
- I recently left a PACE program on _____(please insert date)
- I recently involuntarily lost my credible prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on _____ (please insert date.)
- I am leaving employer or union coverage _____ (please insert date)
- I belong to a Pharmacy assistance program provided by my state.
- I recently returned to the US after living permanently outside of the US. I returned to the US on _____ (please insert date).
- None of these statements apply to me; however I feel I have a special circumstance which would allow me an exception to enroll. (subject to approval). Please explain: _____

AUTHORIZATION FOR THE RELEASE OF INFORMATION: I authorize the treating physician to release documentation such as Medical Records, Explanation of Benefits and/or Insurance (PIP) Payout documents to HealthSun Health Plan, for the sole use of Payment Audit, Coordination of Benefits and/or Quality of Care and Utilization reviews related to such treatment. .

I understand that my signature on this application means that I have read and understand the contents of this application. Please read your Evidence of Coverage document to know what rules you must follow in order to receive coverage with **HealthSun Health Plan.**

X _____
(Your Signature) (Date)

X _____
(Witness) (Date)

*If the individual cannot sign, a court-appointed Legal Guardian or person with Durable Power of Attorney for Health Care (DPAHC), if authorized by state law, or another person who is authorized by State Law, must sign the following line. **Attach a copy of proof of Legal Guardian, (DPAHC), or proof of authorization by State law.**

X _____
(Signature) (Date) (Relationship to Beneficiary)

X _____
(Witness) (Date)

TO BE COMPLETED BY A HEALTHSUN HEALTH PLAN AUTHORIZED REPRESENTATIVE

Name of Representative _____ Representative # _____

Representative Signature: _____ Date: _____

Plan ID Number: _____ Effective date of Coverage: _____

ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (TYPE) _____