Medicare Enrollment form

Thank you for choosing a Medicare plan from Priority Health. Please follow these helpful tips to avoid delays in processing your enrollment. Carefully read, sign and date all necessary portions of the application.

To enroll online visit *prioritymedicare.com*, the Provider/Pharmacy Directory and Formulary are also available here.

If you are enrolling in a dual eligible special needs (D-SNP) plan: ability to enroll will be based on verification that you are entitled to both Medicare and full Medicaid assistance from the State. If your enrollment is not accepted, we will notify you immediately.

You are eligible to join a D-SNP plan if:

1 – You are enrolled in Medicare Parts A and B.
2 – You are eligible for full Medicaid benefits.
3 – You reside within the Priority Health Medicare service area.
4 – You are a United States citizen or lawfully present in the United States; and
5 – You are 21 years of age or older.

Enrollment Form checklist

PriorityMedicare + Kroger	**Priority**Medicare D-SNP + Kroger
☐ Choose an enrollment eligibility selection that applies to you on the first page.	☐ Choose an enrollment eligibility selection that applies to you on the first page.
☐ Check the appropriate box for the plan you wish to join.	☐ Check the appropriate box for the plan you wish to join.
☐ 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 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 below.*
☐ 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.	☐ 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.
☐ Sign and date the form.	☐ Provide your Medicaid insurance information on so we can verify your Medicaid eligibility. Your Medicaid number is located on your MIHealth Card.
	☐ Sign and date the form.

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.

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 888.356.1365, from 8 a.m. – 8 p.m., seven days a week. TTY users should call 711.

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 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 electing to enroll during the annual enrollment period (Oct. 15 through Dec. 7).
- ☐ I am leaving employer or union coverage on (insert date) _____ *(example: retiring and losing coverage through an employer)*. Employer or union name: _____ Group number: _____
- ☐ I am enrolled in a Medicare Advantage plan and want to make a one-time change during the Medicare Advantage Open Enrollment Period (MAOEP)
- ☐ I currently have Medicare Parts A and B due to disability and am turning 65 years of age.
- ☐ 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: newly got 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: newly got extra help, had a change in the level of extra help, or lost extra help)*.
- ☐ 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 recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage 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 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) _____.
- ☐ My plan is ending its contract with Medicare.
- ☐ I recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home). I moved/will move into/out of the facility on (insert date) _____.

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

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

☐ I'm new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started. I was notified on (insert date) __/__/__/.

☐ I'm in a plan that's had a star rating of less than 3 stars for the last 3 years. I want to join a plan with a star rating of 3 stars or higher.

☐ 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 natural disaster.

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 888.356.1365 (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.

1. Check which plan you want to enroll in:
   Available in the following counties: Wayne, Oakland, Macomb, Saginaw, Genesee, Livingston, Washtenaw, Ingham.

☐ **Priority**Medicare + Kroger

☐ **Priority**Medicare D-SNP + Kroger

2. Please choose the name of a doctor (primary care provider [PCP]), otherwise one will be assigned to you (if applicable):

First Name: Last Name:

Last name:	First name:	MI:
Birth date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)		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):		
City:	County:	State: ZIP code:
Mailing address (only if different from your permanent residence address):		
Email address: Include your email if you would like to opt-in to receiving plan documents and other plan information by email. You can unsubscribe at any time.		

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.		
AGENT USE ONLY		
Referring agent:		
Referring agent #:		
Agent received application on:		
Field Market Organization (FMO) name (if applicable):		
FMO received application on (if applicable):		
Scope of Appointment completed:	☐ Yes	Date:
	☐ No	Reason:
OFFICE USE ONLY		
Subscriber ID:		
Effective date of coverage:		
ICEP / IEP / AEP / SEP / OEP (type):		
PBP ID:		
Not eligible:		
Processing rep:		
Date processed:		

Section 1: Priority Medicare + Kroger plans

If you are enrolling in a **Priority**Medicare D-SNP + Kroger plan, please skip to Section 2.

Optional coverage for **Priority**Medicare + Kroger plans ONLY

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 + Kroger, it's an additional monthly premium of $29.

Paying your plan premium

You can pay your monthly plan premium, if there is one, (including any late enrollment penalty that you may have) 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. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance.

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 800.772.1213. TTY users should call 800.325.0778. You can also apply for extra help online at *socialsecurity.gov/prescriptionhelp*. If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare 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 and you may choose a payment option below. 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 two or more months to begin after Social Security or RRB approves the deduction. Depending on when this is approved, you may receive one paper bill. In most cases, if 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 up to the point withholding begins. If Social Security or RRB don't approve your request for automatic deduction, we'll send you a paper bill for your monthly premiums. Should you disenroll from this plan, the same lag in processing time may occur. 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).

If you have questions about the automatic bill payment plan or wish to request a monthly informational only statement, please contact customer service at 888.356.1365. 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.

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

EFT information

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

Section 2: Priority Medicare D-SNP + Kroger plans

If you are enrolling in a **Priority**Medicare + Kroger plan (non D-SNP), please skip this section.

Paying your plan premium

The **Priority**Medicare D-SNP + Kroger plan does not have a premium, however, if we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we will send you a bill in the mail. 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. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance.

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 800.772.1213. TTY users should call 800.325.0778. You can also apply for extra help online at *socialsecurity.gov/prescriptionhelp*.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare 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.

Section 3: All plans

If you are not enrolling in a **Priority**Medicare D-SNP + Kroger plan, please skip questions 1 and 2.

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

   If yes, please provide your Medicaid number: _____

2. **Are you a resident in a long-term care facility, such as a nursing home?** ☐ Yes ☐ No

   If "yes" please provide the following information: _____

   Name of institution: _____

   Address and phone number of institution (number and street): _____

NOTE: Answering questions #3 - #6 is your choice. You can't be denied coverage because you don't fill them out.

3. **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.

4. **What's 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.

5. **Do you or your spouse work?** ☐ Yes ☐ No

6. **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

Please contact Priority Health at 888.356.1365 (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 **+ Kroger plan enrollees:** I understand that beginning on the date that Priority Health Medicare coverage begins using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Priority Health Medicare provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Priority Health Medicare and other services contained in my Priority Health Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. 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:

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

Name:		
Street address:		
City:	**State:**	**ZIP code:**
Phone number:		
Relationship to enrollee (e.g. Power of Attorney or legal guardian):		

We require documentation to verify legal guardianship agreements. Please scan and email or mail legal documents to: Priority Health, MS 1175, 1231 E. Beltline, Grand Rapids, MI 49525 or email: *MedicareCS@priorityhealth.com*. You may also create a member account and send the documentation via secure message.

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 f orm or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded 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 0938-0829. The time required to complete this information collection is estimated to average 10 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, Baltimore, Maryland 21244-1850.

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