



Enrollment form

Freedom Health, Inc. MA-MAPD Individual Enrollment Request 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](https://www.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 monthly Social Security or Railroad Retirement Board benefits.

What happens next?

Send your completed and signed form to:

Freedom Health, Inc.
P.O. Box 151108
Tampa, FL 33684

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

How do I get help with this form?

Call Freedom Health at 1-800-401-2740. 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 Freedom Health al 1-800-401-2740/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.

Phone: 1-800-401-2740 • TTY/TDD: 711

www.freedomhealth.com

FREEDOM HEALTH, INC., P.O. BOX 151108, TAMPA, FL 33684

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

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 "What happens next?" on this page to send your completed form to the plan.



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Section 1 – All fields on this page are required (unless marked optional)**Select the plan you want to join:**

- ☐ Freedom Platinum Plan Rx (HMO): \$0 per month
☐ Freedom Platinum Plus Plan Rx (HMO): \$30 to \$50 per month
☐ Freedom Medicare Plan Rx (HMO): \$0 per month
☐ Freedom Medi-Medi Partial (HMO D-SNP): \$35.90 per month
☐ Freedom Medi-Medi Full (HMO D-SNP)*: \$35.90 per month
*(For QMB and QMB full-benefit dual eligible only)

- ☐ Freedom Platinum Rewards Plan Rx (HMO): \$0 per month
☐ Freedom VIP Savings (HMO C-SNP): \$0 per month
☐ Freedom VIP Care (HMO C-SNP): \$0 per month
☐ Freedom VIP Rewards (HMO C-SNP): \$0 per month
☐ Freedom VIP Savings COPD (HMO C-SNP): \$0 per month
☐ Freedom Savings Plan (HMO)**: \$0 per month
**(MA Only Plan, No Drug Coverage)

LAST name:

FIRST name:

(Optional) MI:

Birth date:

Sex:

☐ Male ☐ Female

Phone number:

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

Address Line 1

Address Line 2

City:

State:

Zip Code:

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

Address Line 1

Address Line 2

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 Freedom Health?

☐ Yes☐ No

Name of other coverage:

Member number for this coverage:

Group number for this coverage:

Dual Special Needs Plans Criteria: If you are applying for any one of the following plans, then please provide your Medicaid ID.

Medicaid ID#

- Freedom Medi-Medi Partial (HMO D-SNP)
- Freedom Medi-Medi Full (HMO D-SNP)

Chronic Special Needs Plans Criteria: If you are applying for any one of the following plans, then please fill out 'Chronic Special Needs Plan (SNP) Pre-Qualification Form' attached at the end of this Application Form.

- Freedom VIP Care (HMO C-SNP)
- Freedom VIP Savings COPD (HMO C-SNP)
- Freedom VIP Savings (HMO C-SNP)
- Freedom VIP Rewards (HMO C-SNP)

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Freedom Health.
- By joining this Medicare Advantage Plan, I acknowledge that Freedom Health 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 Medicare Advantage plan at a time – and that enrollment in this plan will automatically end my enrollment in another Medicare Advantage (MA) plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Freedom Health coverage begins, I must get all of my medical and prescription drug benefits from Freedom Health. Benefits and services provided by Freedom Health and contained in my Freedom Health “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Freedom Health will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if 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 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:

M	M	D	D	Y	Y	Y	Y

If you're the authorized representative, sign above and fill out these fields:

LAST name:	FIRST name:	(Optional) MI:
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Permanent Residence Address:		
<table border="1" style="width: 100%; height: 20px;"></table>		
Address Line 1		
<table border="1" style="width: 100%; height: 20px;"></table>		
Address Line 2		
<table border="1" style="width: 100%; height: 20px;"></table>		
City:	State:	Zip Code:
<table border="1" style="width: 100%; height: 20px;"></table>	<table border="1" style="width: 100%; height: 20px;"></table>	<table border="1" style="width: 100%; height: 20px;"></table>
Phone Number:		
<table border="1" style="width: 100%; height: 20px;"></table>	Relationship to Enrollee:	
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Section 2 - All fields below 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

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, another Hispanic, Latino/a, or Spanish origin☐ Yes, Cuban☐ I choose not to answer

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

Select one if you want us to send you information in an accessible format.

☐ Large print☐ Braille☐ Audio CD

Please contact Freedom Health at 1-800-401-2740 if you need information in an accessible format other than what's listed above. Our office hours are from October 1st to March 31st from 8 a.m. to 8 p.m. EST 7 days a week and from April 1st to September 30th from 8 a.m. to 8 p.m. EST Monday through Friday. TTY users can call 711.

Do you work? ☐ Yes ☐ NoDoes your spouse work? ☐ Yes ☐ No

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Section 2 - All fields below are optional *cont...***Please choose the NAME of a Primary Care Physician (PCP), Clinic or Health Center: (Optional) PCP ID Number:**

FIRST name:

MI: LAST name:

Are you an existing member of this PCP? ☐ Yes ☐ NoE-mail address (optional):

I want to get the following materials via email. Select one or more.

☐ Evidence of Coverage
 ☐ Formulary (List of Covered Drugs)
 ☐ Provider & Pharmacy Directory
 ☐ Summary of Benefits
Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail 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 don't select a payment option, you will get a bill each month.

Please select a premium payment option:☐ Get a bill.

Automatic deduction from your monthly:

☐ Social Security benefit check, or
☐ Railroad Retirement Board (RRB) benefit check

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. DON'T pay Freedom Health the Part D-IRMAA.

OFFICE USE ONLY:**Name of staff member/agent/broker** (if assisted in enrollment):

Effective Date: (MM/DD/YYYY)

Agent Signature: Agent Received Date:

Election Type: ☐ ICEP/IEP ☐ AEP ☐ MA OEP ☐ SEP(type) ☐ Not EligibleAgency of Agent: Current Insurance: Agent Name: (First) (Last) Agent ID#:

TR K-1 ☐ Referral by Provider ☐ Referred by Member ☐ Company Website ☐ Direct Mail ☐ Self
☐ Local Community Event ☐ Media (TV, News Ad, Mag) ☐ Seminar ☐ Seminar Follow-up

TR K-2 ☐ Personal Appt; Benefit Reply Card (SOA/BRC) ☐ Walk-in (SOA) ☐ Formal Event (Submit)
☐ Application Mailed by Beneficiary ☐ Informal Event (SOA) ☐ Voice Recorded Appt (VRA)
Online/Telephonic Application Confirmation #: Date Received: Member ID # - **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. Section 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.





Chronic Special Needs Plan (SNP) Pre-Qualification Form

Special Needs Plan (SNP) is a type of Medicare Advantage coordinated plan focused on individuals with special needs. Freedom Health offers Special Needs Plans (SNPs) designed for people with certain chronic or disabling conditions.

You may be eligible to join one of our chronic-care SNPs if you can answer YES to any of the questions below. Freedom Health will need to obtain verification of the chronic condition from your doctor within 30 days of enrollment. We are required to disenroll you from the special needs plan if we are unable to verify your chronic condition. It is very important, therefore, that you let your doctor know that we will require their verification and that you provide us with accurate contact information for your doctor at the bottom of this form.

CHF/CVD/Diabetes:

Has your doctor or other licensed health care professional diagnosed you with any of the following medical conditions?

(Check all that apply):

Congestive Heart Failure (CHF) ☐ YES ☐ NO

Cardiovascular Disease (CVD) ☐ YES ☐ NO

Diabetes ☐ YES ☐ NO

CHF:

Do you have fluid in your lungs?

☐ YES ☐ NO

Do you have swelling in your feet and legs almost every day because of too much fluid in your body?

☐ YES ☐ NO

Do you take medicine for the fluid in your lungs or to help your heart beat stronger?

☐ YES ☐ NO

CVD:

Have you had a heart attack or been told by your doctor you are at risk to have one?

☐ YES ☐ NO

Do you have heart pain (angina) or leg pain (claudication) brought on when you are active?

☐ YES ☐ NO

Do you take medicine for your heart or circulation?

☐ YES ☐ NO

Diabetes:

Do you check your blood sugar at home?

☐ YES ☐ NO

Do you have high blood sugar?

☐ YES ☐ NO

Do you take medicine to control your blood sugar?

☐ YES ☐ NO

Chronic Obstructive Pulmonary Disease:

Has your doctor or other licensed health care professional diagnosed you with the following medical condition?

(Check if this applies): Chronic Obstructive Pulmonary Disease (COPD)

☐ YES ☐ NO

Do you have difficulty breathing every day or almost every day even with normal activity?

☐ YES ☐ NO

Do you take medicine to help you breathe better?

☐ YES ☐ NO

Doctor/Health Care Provider Contact Information:

Name of your Doctor or Health Care Provider:

LAST Name:

FIRST Name:

Telephone #:

Fax #:

Beneficiary Information:

Beneficiary Signature: _____

Date:

M	M	D	D	Y	Y	Y	Y
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

LAST Name:

FIRST Name:

Freedom Health, Inc. is an HMO with a Medicare contract and a contract with the state Medicaid program. Enrollment in Freedom Health, Inc. depends on contract renewal.