SHARP HEALTH PLAN

2020 Sharp Direct Advantage® Gold Card (HMO) & Sharp Direct Advantage® Platinum Card (HMO) Individual Enrollment Form

Completing this enrollment is your first step to becoming a Sharp Direct Advantage member. You can enroll by mail, by phone, in person or online.

If you and your spouse are both applying, you'll each need to fill out a separate form. For help completing the enrollment form, email us at medicaresales@sharp.com or call us at 1-855-562-8853 (TTY/TDD: 711) to complete your enrollment over the phone. Or, visit **sharpmedicareadvantage.com/enroll/enroll-online** to enroll online.

Please contact Sharp Health Plan if you need information in another language or format (Braille).

How to fill out this form

- Answer all questions and print your answers using blue or black ink. Fill in check boxes with an X.
- Sign the form on page 7 and date it. **Be sure you have read all the pages before you sign**.
- Mail or drop off the original, signed form to:
  Sharp Health Plan, Medicare Dept.
  8520 Tech Way, Suite 201
  San Diego, CA 92123

Next steps

- We'll review your form to ensure it's complete. Then we'll let you know by mail that we've received it.
- We'll let Medicare know that you've applied for Sharp Direct Advantage.
- Within 10 calendar days after Medicare confirms you're eligible, we'll let you know when your coverage starts. Then we'll send your Sharp Direct Advantage member ID card and welcome packet.

2020 Sharp Direct Advantage® Gold Card (HMO) & Sharp Direct Advantage® Platinum Card (HMO) Individual Enrollment Form

Office Use Only:

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

Plan ID #: _____ Received date: _____ ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

PCP #: _____ Application #: _____

To enroll in Sharp Health Plan please provide the following information:

Effective Date of Coverage: MM/DD/YY (/ 01 /)

Please check which plan you want to enroll in.

☐ Sharp Direct Advantage Gold Card ($0 per month, Dental not included)

☐ Sharp Direct Advantage Gold Card ($12 per month, Dental Advantage by Delta Dental [HMO]* included)

☐ Sharp Direct Advantage Platinum Card ($57 per month, Dental Advantage by Delta Dental [HMO]* included)

Last Name:	First Name:	Middle Initial:	☐ Mr. ☐ Ms. ☐ Mrs.

Birth Date: MM/DD/YY (/ /)	Sex ☐ M ☐ F	Primary Phone Number: ( )	Cell Phone Number: ( )

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):

City:	State:	ZIP Code:

Email Address:	☐ Yes, I'd like to receive health plan news and information via email.

Please provide your 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.

* Delta Dental refers to Delta Dental of California.

Paying your plan premium

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know your payment preference. You can pay by mail, "Electronic Funds Transfer (EFT)" or "credit card" 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.

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, "Electronic Funds Transfer (EFT)" or "credit card" each month. You can also choose to pay your premium by automatic deduction from your Social Security or RRB.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part 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 benefit check or be billed directly by Medicare or RRB. DO NOT pay Sharp Health Plan 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 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, 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.

Please select a premium payment option:

☐ Get a bill. (If a payment applies, you will be able to pay by check or credit card monthly.)

☐ Electronic funds transfer (EFT) from your bank account on the 1st of each month. If the 1st of the month falls on a weekend or bank holiday, your draft will occur on the next banking day. Please enclose a VOIDED check or provide the following:

Account type: ☐ Checking ■ Savings

Account holder name: _____ Bank name: _____

Bank routing number: _____ Bank account number: _____

☐ 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. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No

If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Sharp Health Plan? ☐ Yes ☐ No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

3. 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 of institution (number and street): _____

Phone number of institution: _____

4. Are you enrolled in Medi-Cal (Medicaid)? ☐ Yes ☐ No

If yes, please provide your Medi-Cal number: _____

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

Please choose a Primary Care Physician (PCP):

PCP Name: _____ PCP Medical Group: _____

Are you a current patient? ☐ Yes ☐ No

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:

☐ Spanish ☐ Accessible format (like Braille, audio or large print): _____

Please contact Sharp Health Plan at 1-855-562-8853 if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. to 8 p.m. 7 days per week from October 1 to March 31: 7 days per week 8 a.m. to 8 p.m. From April 1 to September 30: Monday through Friday, 8 a.m. to 8 p.m. and on weekends and holidays, your call will be handled by our voicemail system. A Customer Care Representative will return your phone call the next business day. TTY/TDD users should call 711.

Sharp Health Plan provides the Evidence of Coverage, Formulary and Provider Directory online at sharpmedicareadvantage.com. Members can request a paper copy be mailed to them by calling Customer Care at the phone number listed above.

Exhibit 1a: Information to include on or with Enrollment Mechanism – 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 leaving employer or union coverage on (insert date) _____.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ 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 date) _____.
- ☐ 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 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 (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 (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 belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ 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) _____.

Exhibit 1a: Information to include on or with Enrollment Mechanism – Attestation of Eligibility for an Enrollment Period (continued)

☐ 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 a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements apply to you or you're not sure, please contact Sharp Health Plan at 1-855-562-8853 (TTY users should call 711) to see if you are eligible to enroll. We are open from October 1 to March 31: 7 days per week 8 a.m. to 8 p.m. From April 1 to September 30: Monday through Friday, 8 a.m. to 8 p.m. and on weekends and holidays, your call will be handled by our voicemail system. A Customer Care Representative will return your phone call the next business day.

Sharp Health Plan is an HMO plan with a Medicare contract. Enrollment in Sharp Health Plan depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium.

Please Read This Important Information If you currently have health coverage from an employer or union, joining Sharp Health Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Sharp Health Plan. 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: Sharp Health Plan is a Medicare Advantage plan and has 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 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 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: October 15 – December 7 of every year), or under certain special circumstances. Sharp Health Plan serves a specific service area. If I move out of the area that Sharp Health Plan 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 Sharp Health Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Sharp Health Plan when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border. I understand that beginning on the date Sharp Health Plan coverage begins, I must get all of my health care from Sharp Health Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Sharp Health Plan and other services contained in my Sharp Health Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR SHARP HEALTH PLAN WILL PAY FOR THE SERVICES.** I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Sharp Health Plan, he/she may be paid based on my enrollment in Sharp Health Plan. **Release of Information:** By joining this Medicare health plan, I acknowledge that Sharp 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 Sharp Health Plan 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: **x**	**Today's Date:**
If you are the authorized representative, you must sign above and provide the following information:	
Name:	Relationship to Enrollee:
Address:	Phone Number: ( )

Non-discrimination Notice

Sharp Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Sharp Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (such as large print, audio, accessible electronic formats, or other formats)
- Provides free language services to people whose primary language is not English,such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Care at 1-855-562-8853.

If you believe that Sharp Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator at:

- Address: Sharp Health Plan Appeal/Grievance Department 8520 Tech Way, Suite 201 San Diego, CA 92123-1450
- Telephone: 1-855-562-8853 (TTY/TDD: 711) Fax: (858) 636-2256

You can file a grievance in person or by mail, fax, or you can also complete the online Grievance/Appeal form on the Plan's website sharphealthplan.com. Please call our Customer Care team at 1-855-562-8853 if you need help filing a grievance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.