



INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

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 receive 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?

Mail your completed and signed form to:

Sharp Health Plan Medicare Dept.
8520 Tech Way, Suite 201
San Diego, CA 92123

Once they process your request to join, a plan representative will contact you.

How do I get help with this form?

Call 1-855-562-8853 (TTY/TDD: 711).

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Sharp Health Plan al 1-855-562-8853 (TTY/TDD: 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.

Office Use Only:

Name of staff member (if assisted in enrollment): _____ CA License #: _____
 Plan ID #: _____ Received date: _____ ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____
 PCP #: _____ Application #: _____ Effective date of coverage: _____

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

Select the plan you want to join:

- Sharp Direct Advantage VIP Plan (\$0 per month, Dental Advantage by Delta Dental [HMO]* included)
- Sharp Direct Advantage Gold Card (\$0 per month, Dental not included)
- Sharp Direct Advantage Gold Card (\$13 per month, Dental Advantage by Delta Dental [HMO]* included)
- Sharp Direct Advantage Platinum Card (\$58 per month, Dental Advantage by Delta Dental [HMO]* included)

The comprehensive dental coverage is provided through DeltaCare USA, an HMO-type plan offered by Delta Dental of California. You will be auto-assigned a network dentist in your area. If you would like to change to another network provider, contact Delta Dental.

First name: _____ Last name: _____ Middle initial: _____

Birth Date: MM/DD/YY
/ /

Sex:
 Male Female

Phone number:
()

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

City:

County:

State:

ZIP Code:

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

Street address:

City:

State:

ZIP Code:

Email Address:

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

Your Medicare information:

Medicare Number: _____ - _____ - _____

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Sharp Health Plan?

Yes No

Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage: _____

* Delta Dental refers to Delta Dental of California.

IMPORTANT: Read and sign below:

I must keep both Hospital (Part A) and Medical (Part B) to stay in Sharp Health Plan.

- By joining this Medicare Advantage Plan, I acknowledge that Sharp Health Plan 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 Sharp Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Sharp Health Plan. Benefits and services provided by Sharp Health Plan and contained in my Sharp Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Sharp Health Plan 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're the authorized representative, sign above and fill out these fields:

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 Sharp Health Plan at 1-855-562-8853 if you need information in an accessible format other than what's listed above. Our office hours are 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.

Do you work? Yes No

Does your spouse work? Yes No

Please choose a Primary Care Physician (PCP):

PCP Name: _____ PCP Medical Group: _____

Are you a current patient? Yes No

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, 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 Sharp Health Plan the Part D-IRMAA.

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

- I am new to Medicare.
- I am using the 5-star Special Enrollment Period (Dec. 8, 2021 – Nov. 30, 2022) to switch from my current Medicare plan to a Medicare plan with a “5-star” quality rating.
- I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- I am leaving employer or union coverage on (insert date) _____.
- 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 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 applies to you or you're not sure, please contact Sharp Health Plan at 1-855-562-8853, 711, to see if you are eligible to enroll. Our office hours are 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.