SHARP HEALTH PLAN

2019 Sharp Direct Advantage℠ Basic (HMO) & Sharp Direct Advantage℠ Premium (HMO) Enrollment Form

Completing your enrollment is your first step to becoming a Sharp Direct Advantage Medicare member. You can enroll by mail, by phone, in person or online. These plans are exclusively for former employees of Sharp HealthCare and their Medicare-eligible dependents.

If you and your spouse are both applying, you'll each need to fill out a separate form. For help completing the enrollment form, or to complete your enrollment over the phone, call us at 1-855-562-8853 (TTY/TDD 711). 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 5 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 ID card and information for new members.

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Office Use Only:

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

Plan ID #:802 Received date:_____ ICEP/IEP: _____ AEP: _____ SEP (type): ✓ Not Eligible: _____

PCP #:_____ Application #:_____

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

Requested start date of coverage: MM/DD/YYYY (/ 01 /)

Employer or Union Name: **Sharp HealthCare Former Employees**	Group #: 1002010

Please check which plan you want to enroll in.

- ☐ Sharp Direct Advantage Basic ($0 per month, Dental not included)
- ☐ Sharp Direct Advantage Basic ($11 per month, Dental Advantage by Delta Dental* included)
- ☐ Sharp Direct Advantage Premium ($59 per month, Dental not included)
- ☐ Sharp Direct Advantage Premium ($70 per month, Dental Advantage by Delta Dental* included)

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

Birth Date: MM/DD/YYYY (/ /)	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.

Please read and answer these important questions:

1. Are you the former employee of Sharp HealthCare? ☐ **Yes** ☐ **No**

If yes, employment end date (MM/DD/YY): _____ If no, name of retiree: _____

2. Are your covering a spouse or dependent(s) under this employer plan? ☐ **Yes** ☐ **No**

If yes, name of spouse: _____

Name(s) of dependent(s): _____

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

4. 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.

5. 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:
_____	_____	_____

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

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

7. 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: _____ Phone number of institution: _____

Address of institution (number and street): _____

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 future 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 (TTY/TDD users should call 711). Our office hours are from 8 a.m. to 6 p.m., Monday to Friday.

Sharp Health Plan is an HMO plan with a Medicare contract. Enrollment in Sharp Health Plan depends on contract renewal. You must continue to pay your Part B premium.

This information is not a complete description of benefits. Contact the plan for more information. 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.

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 statement carefully and check the box if the statement applies to you.

By checking the following box 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 a former employee or spouse/domestic partner/dependent of a former employee of Sharp HealthCare and I am not actively employed by Sharp HealthCare.

If this statement does not apply to you or you're not sure, please contact Sharp Health Plan at 1-855-562-8853 (TTY/TDD users should call 711) to see if you are eligible to enroll. We are open Monday through Friday, 8 a.m. to 6 p.m.

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 200, San Diego, CA 92123-1450
- Telephone: 1-855-562-8853 (TTY/TDD: 711)
  Fax: 1-619-740-8572

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 (TTY/TDD).

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