

SHARP Health Plan

2027 Sharp Direct Advantage[®] Employer Group Enrollment Form

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

This plan is open to all Medicare-eligible City of San Diego retirees, sponsored by the San Diego Public Employee Benefit Association (SDPEBA). SDPEBA membership is not required to join this plan. Please contact Sharp Health Plan if you need information in another language or format (e.g., Braille).

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 27-November 24 each year (for coverage starting in January)
- Within three 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:

- 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.

Important information:

- The Medicare application is intended for individual coverage only. If you and your spouse/dependent are both applying for coverage, then each of you will need to complete a separate enrollment form.
- **Note:** If your spouse/dependent is not eligible for Medicare, then he/she will need to complete the Non-Medicare Enrollment Application. Please contact SDPEBA at 1-888-315-8027 or visit sdpeba.org to download the enrollment form.

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.

Individuals experiencing homelessness

If you want to join a plan but do not have a 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.

City of San Diego Retiree

Are you the City of San Diego retiree? ☐ Yes ☐ No

If you answered no, are you the surviving spouse of a City of San Diego retiree? ☐ Yes ☐ No

Retiree Last Name:

Retiree First Name:

Retiree Middle Initial:

Are you Medicare eligible?

☐ Yes If yes, complete the enclosed Medicare Enrollment Application.

☐ No If no, complete the Non-Medicare Retiree Enrollment Application (1-888-315-8027/sdpeba.org).

If yes, are you covering a spouse/dependent? ☐ Yes (If yes, complete the section below.) ☐ No

Spouse/Dependent of City of San Diego Retiree

Last Name:

First Name:

Middle Initial:

Are you Medicare eligible?

☐ Yes If yes, complete an additional Medicare Enrollment Application.

☐ No If no, complete the Non-Medicare Retiree Enrollment Application (1-888-315-8027 or sdpeba.org).

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To Enroll in Sharp Direct Advantage, Please Provide the Following Information:			
Effective Date of Coverage: MM/DD/YY (/ 01 /)			
Employer or Union Name: San Diego Public Employee Benefit Association (SDPEBA)			Group #: 1002001-01
I would like to enroll in the following plan: ☒ Sharp Direct Advantage (HMO) (\$239 per month) (21955)		This plan is for Medicare-enrolled retirees only. If you are not eligible for Medicare, please contact SDPEBA at 1-888-315-8027 for the Non-Medicare Enrollment Form or visit sdpeba.org to download the enrollment form.	
Last Name:		First Name:	Middle Initial:
Birth date: MM/DD/YYYY / /		Social Security number: - -	Sex: ☐ Male ☐ Female
Permanent Residence Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):			
City:	County:	State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Street Address):			
City:		State:	ZIP Code:
Cell Phone Number: ()		Home Phone Number: ()	
Other Phone Number: ()		Email Address:	
☐ I have read and consent to receive text messages or automated, prerecorded voice calls according to the terms and conditions set forth by Sharp Health Plan. Visit sharphealthplan.com/terms for more information.			
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.	

Please Read and Answer These Important Questions:

Are you the City of San Diego retiree? ☐ Yes ☐ No

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

Are you covering a Medicare-eligible spouse or dependent(s) under this employer or union plan?

☐ Yes ☐ No If yes, name of spouse/dependent(s): _____

If you intend to cover a Medicare or non-Medicare eligible spouse/dependent, then he/she will need to complete a separate enrollment application (Medicare or Non-Medicare).

Do you or your spouse work? ☐ Yes ☐ No

Some individuals may have other drug coverage, including other private insurance, worker's compensation, VA benefits or state pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Sharp Direct Advantage? ☐ 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: _____

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):

Existing Patient: ☐ Yes ☐ No

PCP Name: _____ PCP Medical Group: _____

Need to find a provider ? Visit sharpmedicareadvantage.com/findaprovider to use our online search tool.

The fields in this section are optional" and box below

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

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 (e.g., Braille, larger print, Audio CD or Data CD): _____

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 hours of operation are 7 a.m. to 8 p.m. Pacific time, seven days a week, all year round.

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.

Please Read and Answer These Important Questions:

Typically, you may enroll in a Medicare Advantage plan only during the City of San Diego Medicare retirees' open enrollment period, which is in November 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 a retiree or spouse/domestic partner/dependent of a retiree of the City of San Diego enrolling during open enrollment (October 27 - November 25, 2025).
- ☐ I am new to Medicare.
- ☐ I am leaving employer or union coverage on (insert date) _____.

If none of these statements 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. Our office hours are Oct. 1 – March 31 from 8 a.m. – 8 p.m. Pacific time, seven days a week and April 1 – Sept. 30 from 8 a.m. – 8 p.m., Monday through Friday. Calling after hours will direct you to our voicemail system, and a Customer Care representative will return your call the next business day.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

Sharp Direct Advantage 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 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. It is my responsibility to inform the plan 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, if an enrollment period is available (e.g., annual enrollment period), or under certain special circumstances.

Sharp Direct Advantage serves a specific service area. If I move out of the area that Sharp Direct Advantage serves, I need to notify the plan so I can disenroll and find a plan in my new area. Once I am a member of Sharp Direct Advantage, 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 Direct Advantage when I get it to understand the 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 from the date Sharp Direct Advantage coverage begins, I must get all of my health care from Sharp Direct Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Sharp Direct Advantage and other services contained in my Sharp Direct Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR SHARP DIRECT ADVANTAGE 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 Direct Advantage, he/she may be paid based on my enrollment in Sharp Direct Advantage.

The undersigned expressly consents and agrees that Sharp Health Plan, its business associates and other third parties, including debt collectors, may send periodic electronic communications for any lawful purpose, including routine business and/or marketing purposes, at any email address or phone number he/she provides. Messages may be sent by text (SMS), email, automatic telephone dialing systems (auto-dialer), prerecorded message or live operator call. Message frequency will vary. Message and data rates apply. The undersigned may opt out of receiving further automated, electronic communications at any time by texting STOP or calling 1-855-562-8853. Whether the undersigned agrees to receive these messages will not affect care or coverage in any way. Visit www.sharphealthplan.com/terms for complete Terms of Use.

Please Read and Sign Below, continued

Release of Information: By joining this Medicare health plan, I acknowledge that Sharp Direct Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Sharp Direct Advantage will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that 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 in which 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:
()**For individuals helping enrollee with completing this form only**

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name:

Relationship to Enrollee:

Signature:

National Producer Number (Agents/Brokers only):

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 of Medicare confirming your eligibility, we'll let you know when your coverage starts. Then, we'll send your Sharp Direct Advantage ID card and information for new members.

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.

Nondiscrimination Notice

Sharp Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Sharp Health Plan does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. A copy of the Nondiscrimination Notice can also be accessed at sharpmedicareadvantage.com.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters.
- Provides reasonable modifications for individuals with disabilities, and appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternative formats, such as braille or large print, free of charge and in a timely manner, when such modifications, aids, and services are necessary to ensure accessibility and an equal opportunity to participate to individuals with disabilities.
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters and language assistance services, including electronic and written translated documents and oral interpretation, free of charge and in a timely manner, when such services are a reasonable step to provide meaningful access to an individual with limited English proficiency. If you need these services, contact Customer Care at 1-800-359-2002 (TTY 711).

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, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability, you can file a grievance with our Civil Rights Coordinator and Section 1557 Nondiscrimination Coordinator at:

- Address: Sharp Health Plan Compliance Department, Attn: Director of Compliance and Regulatory Affairs Department, 8520 Tech Way, Suite 200, San Diego, CA 92123-1450
- Telephone: 1-800-359-2002 (TTY 711)
- Fax: 1-619-740-8572
- Email: shpcompliance@sharp.com

You can file a grievance in person or by mail or 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 1-800-359-2002 if you need help filing a grievance. You can also file a discrimination complaint if there is a concern of discrimination based on race, color, national origin, age, disability or sex 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 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, 1-800-537-7697 (TDD).

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

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002.

IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services (§ 92.11)

English

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call at 1-855-562-8853 (TTY: 711) or speak to your provider.

Español

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-562-8853 (TTY: 711) o hable con su proveedor.

台語

注意：如果您說[台語]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-855-562-8853 (TTY: 711) 或與您的提供者討論。」

Tagalog

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-562-8853 (TTY: 711) o makipag-usap sa iyong provider.

Việt

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-855-562-8853 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn."

العربية

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-855-562-8853 (711) أو تحدث إلى مقدم الخدمة."

한국어

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-855-562-8853 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오."

日本語

注: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-855-562-8853 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

Deutsch

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-855-562-8853 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Français

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-562-8853 (TTY: 711) ou parlez à votre fournisseur.

РУССКИЙ

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-562-8853 (TTY: 711) или обратитесь к своему поставщику услуг.

हिंदी

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-562-8853 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

ລາວ

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-855-562-8853 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

Italiano

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-855-562-8853 (tty: 711) o parla con il tuo fornitore.

Português do Brasil

ATENÇÃO: Se você fala Português do Brasil, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-855-562-8853 (TTY: 711) ou fale com seu provedor.

తెలుగు

సావధానం: మీరు తెలుగు మాట్లాడితే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉంటాయి. యాక్సెస్ చేయగల ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక సహాయాలు మరియు సేవలు కూడా ఉచితంగా అందుబాటులో ఉంటాయి. 1-855-562-8853 (TTY: 711) కి కాల్ చేయండి లేదా మీ ప్రొవైడర్‌తో మాట్లాడండి.