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Enrollment Application

Harvard Pilgrim Health Care Stride℠ (HMO)/(HMO-POS) Medicare Advantage Plan Individual Enrollment Request Form

ENROLLMENT INSTRUCTIONS

The following steps must be completed to become a member of Harvard Pilgrim Health Care's Stride℠ (HMO)/(HMO-POS) Medicare Advantage Plan.

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug 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 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 bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
Harvard Pilgrim Stride of NH (HMO)
Attn: Enrollment
PO Box 16755
Lubbock, TX 79490-9901
Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Harvard Pilgrim Health Care at (888) 609-0692. 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 Harvard Pilgrim Health Care al (888) 609-0692/ TTY 711. o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia enespañol y un representante estará disponible paraasistirle.

Additional ways to enroll:

- Call (855) 243-1145 TTY: 711 to enroll over the phone
- Enroll online at kit.hpforlife.org
- Fax number 813-513-7302

Medicare beneficiaries may also enroll through the CMS Medicare Online Enrollment Center located at http://Medicare.gov
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.

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- NEW. 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.

Please print **AGENT USE ONLY**

Name of Staff Member/Agent/Broker (If assisted in enrollment)/Signature ________________ Agent NPN ________________

Election Type (circle) ICEP/IEP AEP MA OEP SEP (Type)________________

Plan ID# ________________

Agency of Agent ________________ Date Received ____/____/____

Current Insurance ________________

Scope of Appointment received? ❒ Yes ❒ No If No, ❒ App mailed to Agent Seminar (Date/Location)________________

To Enroll in Stride℠ (HMO)/(HMO-POS), Please Provide the Following Information

Request to enroll: ❒ New Membership ❒ Plan Change If plan change, Existing Member ID #________________

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

Select the plan you want to join **Effective Date** ____/____/____

STATE		PLANS AVAILABLE	MONTHLY PREMIUM	AVAILABLE IN THE FOLLOWING COUNTIES
New Hampshire	❒	Stride℠ (HMO) Basic Rx (HMO)	$0	Belknap, Cheshire, Grafton, Hillsborough, Merrimack, Rockingham, & Sullivan
	❒	Stride℠ (HMO) Value Rx (HMO)	$57	Belknap, Cheshire, Grafton, Hillsborough, Merrimack, Rockingham, & Sullivan
	❒	Stride℠ (HMO) Choice Rx (HMO-POS)	$68	Belknap, Cheshire, Grafton, Hillsborough, Merrimack, Rockingham, & Sullivan
	❒	Stride℠ (HMO) Value Rx Plus (HMO)	$141	Belknap, Cheshire, Grafton, Hillsborough, Merrimack, Rockingham, & Sullivan
	❒	Stride℠ (HMO) Value Rx Plus (HMO)	$146	Strafford

*The amount you pay will vary depending on whether you receive Extra Help from Medicare for prescription drug coverage. If you are enrolled in a State Medicare Savings Program, you may automatically qualify for Extra Help.

First Name ______ Last Name ______ Middle Initial ______ (optional) ❒ Mr. ❒ Mrs. ❒ Ms.

Birth Date ____/____/______ (MM DD YYYY) Email Address (optional) ______ Sex ❒ Male ❒ Female

Primary Phone Number: ☐☐☐☐☐☐☐☐☐☐

☐ This is a mobile number (optional)

Alternate Phone Number (optional): ☐☐☐☐☐☐☐☐☐☐

☐ This is a mobile number (optional)

Permanent Residence Street Address (P.O. Box not allowed unless you do not have a permanent residence)

Street Number ______ Street Name ______ Lot/Apartment ______

City ______ County (optional) ______ State ______ ZIP Code ______

Mailing Address (only if different from your Permanent Residence Address) (P.O. Box allowed):

Street Number ______ Street Name ______ Lot/Apartment ______

City ______ State ______ ZIP Code ______

Emergency contact: (optional)

First Name ______ Last Name ______ MI ______

Phone Number (____) ______ Relationship to you ______

Your Medicare Information:

Medicare Number: ___ ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

Please Read This Important Information for MA-PD Plans

If you currently have health coverage from an employer or union, joining Stride℠ (HMO)/(HMO-POS) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Stride℠ (HMO)/(HMO-POS). 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 Answer This Important Question:

1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to **Stride℠ (HMO)/(HMO-POS)**? ❑ YES ❑ NO

Name of other coverage ______ Member number for this coverage ______ Group number for this coverage ______

IMPORTANT: Read and Sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Stride[SM] (HMO)/(HMO-POS)
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Stride[SM] (HMO)/(HMO-POS) 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 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 Stride[SM] (HMO)/(HMO-POS) coverage begins, I must get all of my medical and prescription drug benefits from Stride[SM] (HMO)/(HMO-POS). Benefits and services provided by Stride[SM] (HMO)/(HMO-POS) and contained in my Stride[SM] (HMO)/(HMO-POS) "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Stride[SM] (HMO)/(HMO-POS) 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 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 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** ____________

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

Name ____

Address ____

Phone Number (________) __________________ Relationship to Enrollee: ________________________

PRIVACY ACT STATEMENT The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

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.

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

2. 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.**

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

❑ Braille ❑ Large print ❑ Audio CD

Please contact **Harvard Pilgrim** at (888) 609-0692 if you need information in an accessible format or language other than what's listed above. Our office hours are October 1 to March 31, from 8 a.m. to 8 p.m., 7 days a week, April 1 to September 30 from 8 a.m. to 8 p.m. Monday through Friday. (TTY users should call 711.)

4. Do you work? ❑ YES ❑ NO Does your spouse work? ❑ YES ❑ NO

List your Primary Care Physician (PCP), clinic, or health center:

FIRST Name: ____________ MI: ____ LAST Name: ____________

PCP ID Number: ____________

Are you an existing patient of this PCP? ❑ YES ❑ NO

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

❑ Plan Documents: Includes Annual Notice of Change (ANOC), Evidence of Coverage (EOC) and other plan-related material.

❑ Plan literature, tips and educational material: Includes health and wellness suggetions and useful materials about how to get the most value from your Harvard Pilgrim Stride[SM] (HMO)/(HMO-POS) plan.

Email Address: ____________

Paying Your Plan Premiums

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay your monthly plan premium including any late enrollment penalty that you currently have or may owe by mail or Electronic Funds Transfer (EFT) 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 check 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**. DON'T pay Harvard Pilgrim Health Care 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 (800) 772-1213. TTY users should call (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:
If you don't select a payment option, you will get a bill each month –(does not apply to $0 premium).

- ❒ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

  I get 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. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums).
- ❒ Get a monthly bill
- ❒ Electronic funds transfer (EFT) from your bank account each month (see voided check below)

  Note: **It may take up to two months for your premium payment option to take effect. You will be responsible for any premiums up to that point.**

Please enclose a VOIDED check or provide the following:

Account holder name: ______________________

Bank routing number: ______________________

Bank account number: ______________________

Account type:

❒ Checking

❒ Savings

YOUR NAME 123
678 Maine Street
Anywhere, MI 12345 DATE ________

VOID

PAY TO THE ORDER OF ______________________ $ ______

______________________ DOLLARS

:999888000 :00123456789 123:

Routing Number **Account** Number **Check** Number

Harvard Pilgrim Health Care

Information to Include 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 enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) with an effective date of (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 am leaving employer or union 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)________
- ❑ 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 an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact Harvard Pilgrim Health Care at **(877) 431-4742** (TTY: **711**) to see if you are eligible to enroll. We are open Oct.1 to March 31, from 8am - 8pm, Mon.- Fri, April 1 to Sept. 30, 8am - 8pm, 7 days a week.

AGENT USE ONLY

Enrollee's LAST Name: ________ **FIRST Name:**________

Medicare Claim #________ **Effective Date:**________