Individual enrollment form

Devoted HEALTH PLANS

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)

To join a Dual-Eligible Special Needs Plan (D-SNP), you must qualify for both Medicare and Medicaid. To join a Chronic Condition Special Needs Plan (C-SNP), you must have a qualifying chronic condition.

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.
- If you need to pay a plan premium, your plan will send you a bill. You can choose to sign up to have your premium payments deducted from your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Mail
Devoted Health – Enrollment
PO Box 211157
Eagan, MN 55121

Fax
1-833-434-0535

Once we process your request to join, we'll contact you.

How do I get help with this form?

Call Devoted Health at 1-800-385-0916 (TTY 711). Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Devoted Health al 1-800-385-0916 (TTY 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.

What if I'm experiencing homelessness?

If you don't have a permanent residence, you can use a Post Office Box, the address of a shelter or clinic, or the address where you get mail (like your Social Security checks) as your permanent residence address on this application.

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Section 1:

All fields on this page and the next page are required (unless marked optional).

CHOOSE YOUR PLAN

Plan name (located on the front cover of Summary of Benefits)**:**

Monthly plan premium:
- ☐ $0
- ☐ $

Plan number (PBP/Segment)**:**

H

County (optional)**:**

PROVIDE YOUR PERSONAL INFORMATION

First name:

Last name:

Middle initial (optional)**:**

Preferred first name (optional)**:**

Birth date (mm/dd/yyyy)**:**

Sex*:
- ☐ Male
- ☐ Female

If you want to get text messages from Devoted Health (86685), provide your cell phone number below.**

Primary phone:

Secondary phone (optional)**:**

Email address (optional)**:**

Would you like to get most plan communications electronically, on our secure member portal? If YES: We'll email or text you when there's a new communication. If we don't have your email or cell number, you'll keep getting paper mail. (optional)

☐ Yes ☐ No

Permanent residence street address (where you live - not a PO Box)**:**

City:

State:

Zip:

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

City:

State:

Zip:

PROVIDE YOUR MEDICARE INFORMATION

Medicare number:

*Please choose the sex that Social Security has on file for you. **By providing my cell phone number, I consent to receiving text messages regarding my plan and care from Devoted Health and its related medical practices. Msg frequency varies. Msg & data rates may apply. Reply STOP to cancel messages and HELP for help. **devoted.com/terms-of-use and devoted.com/privacy-policy**

LET'S CHECK IF YOU CAN JOIN A PLAN RIGHT NOW

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).
- ☐ 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 / / .
- ☐ I recently was released from incarceration. I was released on / / .
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on / / .
- ☐ I recently obtained lawful presence status in the United States. I got this status on / / .
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on / / .
- ☐ 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 / / .
- ☐ 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 / / .
- ☐ I recently left a PACE program on / / .
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on / / .
- ☐ I am leaving employer or union coverage on / / .
- ☐ 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 / / .
- ☐ 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 / / .
- ☐ 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. (Be sure to check the other statement that applied to you).
- ☐ I signed up for Medicare coverage between January 1 and March 31 during the General Enrollment Period (GEP). My Medicare coverage will begin July 1.
- ☐ I have a chronic condition(s) and qualify to enroll in a Special Needs Plan (SNP) that serves the condition(s). This is my first enrollment into a chronic care SNP.

If none of these statements applies to you or you're not sure, please contact Devoted Health at **1-800-385-0916** (TTY 711) to see if you are eligible to enroll. We are open 8am to 8pm, Monday to Friday (from October 1 to March 31, 8am to 8pm, 7 days a week).

ANSWER THESE IMPORTANT QUESTIONS

Are you a veteran? (optional) ☐ Yes ☐ No

Will you have other prescription drug coverage (like VA, TRICARE) in addition to your Devoted Health plan? ☐ Yes ☐ No

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

Are you enrolled in your state Medicaid program? ☐ Yes ☐ No

If yes, what is your Medicaid number? (found on your Medicaid card)

IMPORTANT: READ AND SIGN BELOW

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Devoted Health.
- By joining this Medicare Advantage Plan, I acknowledge that Devoted Health 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).
- My response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- 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).
- If enrolling in a SNP: By joining this plan, I confirm that I meet the eligibility criteria.
- 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 when my Devoted Health coverage begins, I must get all of my Medicare medical benefits (and prescription drug benefits, if applicable) from Devoted Health. Benefits and services provided by Devoted Health and contained in my Devoted Health "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Devoted Health will pay for benefits or services that my Devoted Health plan doesn't cover.
- 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** (mm/dd/yyyy)**:**

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

Name:	**Address:**

Phone number:	**Relationship to enrollee:**

Section 2:

These questions are optional. We can't deny coverage because you don't fill them out.

TELL US ABOUT YOURSELF

Are you Hispanic, Latino/a, or of Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer**
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin

What's your race? Select all that apply.

- ☐ White
- ☐ Asian Indian
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Black or African American
- ☐ Chinese
- ☐ Japanese
- ☐ Other Asian
- ☐ Vietnamese
- ☐ American Indian or Alaska Native
- ☐ Filipino
- ☐ Korean
- ☐ Other Pacific Islander
- ☐ **I choose not to answer**

What language would you like us to send materials in? (if this is blank, we'll send materials in English)

☐ English ☐ Spanish

Do you need one of the following accessibility accommodations for information we send you? (choose only one)

☐ None ☐ Braille ☐ Audio CD ☐ Large print

Please contact Devoted Health at **1-800-385-0916** (TTY 711) if you need information in an accessible format other than what's listed above. Our office hours are 8am to 8pm, Monday to Friday (from October 1 to March 31, 8am to 8pm, 7 days a week).

Do you work? ☐ Yes ☐ No **If you're married, does your spouse work?** ☐ Yes ☐ No

TELL US ABOUT YOUR PRIMARY CARE PROVIDER (PCP)

Your PCP is the main doctor you see for your care. Please tell us who you want to be your PCP.
HMO members: If you leave this section blank or list an out-of-network provider, we'll choose a PCP for you.

Full name:	**Address:**
PCP ID number:	**Are you currently a patient?** ☐ Yes ☐ No

PAYING YOUR PLAN PREMIUMS

If your plan has a monthly premium (including any late enrollment penalty you may owe), you can pay it by mail each month, or with a credit or debit card on our secure online portal. **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 Devoted Health the Part D-IRMAA.

How would you like to pay? Only choose one. If you don't select an option below, we'll send a monthly bill.

- ☐ Send me a monthly bill
- ☐ Take it out of my monthly Social Security check*
- ☐ Take it out of my monthly Railroad Retirement Board (RRB) check*

*It may take at least 2 months for your premium to start coming out of your check. The first deduction usually includes all premiums due up to that point.

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 and 1860D-1 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.

To be completed by a licensed Sales Representative / Agent only

☐ **New member** ☐ **Plan change**

Licensed sales agent full name:	**Initial receipt date:**
Licensed sales agent NPN:	**Proposed effective date:**
Licensed sales agent phone number:	

Method of contact:

☐ Agent generated	☐ Marketing campaign	☐ Business or community partner
☐ Sales seminar	☐ Family or friend referral	☐ Search engine
☐ Community event	☐ Provider office	☐ Other

Select enrollment period:

☐ AEP	☐ SEP (losing coverage)	☐ SEP (moved coverage area)
☐ MA OEP	☐ SEP (Dual eligible)	☐ SEP (non-renewal)
☐ ICEP (MA enrollees)	☐ SEP (LIS)	☐ SEP (other)
☐ IEP (MA-PD enrollees)	☐ OEPI	

SEP reason (if you selected "SEP (other)"):	**SEP eligibility date:**
Licensed sales rep signature (required):	

Please send your completed form to:

Mail
Devoted Health – Enrollment
PO Box 211157
Eagan, MN 55121

Fax
1-833-434-0535