Health Alliance™

Medicare Advantage Enrollment Request Form – Illinois: Health Alliance Medicare POS Enrich

January 1, 2025 – December 31, 2025

2025

Toll-free (888) 382-9771 (TTY 711)
Fax (217) 902-9785
HealthAlliance.org/Medicare

MDMKHA25-ENRenrollfm-0624 • H1463_25_119028_C

OMB No. 0938-1378
Expires: 6/30/2026

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 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:

Health Alliance™ Medicare
Application Processing Center
3310 Fields South Drive
Champaign, IL 61822

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

How do I get help with this form?

Call Health Alliance Medicare at (888) 382-9771 (TTY 711).

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

En español: Llame a Health Alliance al (888) 382-9771 o a Medicare gratis al (800) 633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

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.

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.

Health Alliance™
(888) 382-9771 (TTY 711)
Fax (217) 902-9785
HealthAlliance.org/Medicare

Health Alliance™

(888) 382-9771
3310 Fields South Drive, Champaign, IL 61822

MEDICARE ADVANTAGE ENROLLMENT REQUEST FORM

Agent/Office Staff Use Only:
Name of staff member/agent/broker (if assisted in enrollment): _____
Date Received: _____ Effective Date of Coverage: _____ NPN: _____
Check one: ☐ ICEP/IEP ☐ AEP ☐ SEP/OEP (attestation form must be included if SEP is checked)
Marketing Meeting Date: _____

Please contact Health Alliance™ Medicare if you need information in another language or format (Braille).

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

Select the plan you want to join:

☐ POS Enrich Rx (HMO-POS) $177 per month

FIRST Name: LAST Name: Middle Initial (Optional):

Birth Date:	Sex:	Phone Number:
(__ __ / __ __ / __ __ __ __) M M D D Y Y Y Y	☐ 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 (Optional): _____ State: _____ ZIP Code: _____

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

Street Address: _____City: _____ State: _____ ZIP Code: _____

Your Medicare information:

Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Health Alliance Medicare?
☐ 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 Health Alliance Medicare.
- By joining this Medicare Advantage plan, I acknowledge that Health Alliance Medicare 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 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).
- I understand that when my Health Alliance Medicare coverage begins, I must get all of my medical and prescription drug benefits from Health Alliance Medicare. Benefits and services provided by Health Alliance Medicare and contained in my Health Alliance Medicare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Health Alliance Medicare 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: 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 in this section are optional

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

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

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

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer.**

What is your gender: Select one.

☐ Woman
☐ Man
☐ Non-binary
☐ I use a different term: _____
☐ **I choose not to answer.**

Which of the following best represents how you think of yourself? Select one.

☐ Lesbian or gay
☐ Straight, that is, not gay or lesbian
☐ Bisexual
☐ I use a different term: _____
☐ I don't know.
☐ **I choose not to answer.**

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 ☐ Data CD

Please contact Health Alliance Medicare at (888) 382-9771 if you need information in an accessible format other than what's listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. TTY users should call 711. Voicemail is used on holidays and weekends from April 1 to September 30.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

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

_____

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

☐ Using your coverage
☐ Information and updates about your plan

E-mail address: _____

Paying your plan premiums

You can pay your monthly plan premium 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 Health Alliance Medicare the Part D-IRMAA.

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): _____

PRIVACY ACT STATEMENT

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

DISCRIMINATION IS AGAINST THE LAW

Health Alliance™ complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex (including discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes). Health Alliance does not exclude people or treat them differently because of race, color, national origin, age, disability or sex (including discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes). Health Alliance:

- 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 (large print audio, accessible electronic formats, 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 Service.

If you believe that Health Alliance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex (including discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes), you can file a grievance with: Health Alliance Medicare, Member Services, 3310 Fields South Drive, Champaign, IL 61822, telephone for members: (800) 965-4022 TTY:711, fax: (217) 902-9705, MemberServices@HealthAlliance.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Member Services is available to help you. 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, (800) 368-1019, TTY: (800) 537-7697. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla Español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame (800) 965-4022 (TTY: 711).

注意：如果你講中文，語言協助服務，免費的，都可以給你。呼叫 (800) 965-4022 (TTY: 711)。

UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń (800) 965-4022 (TTY: 711).

LƯU Ý: Nếu bạn nói tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi (800) 965-4022 (TTY: 711).

주의: 한국어를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 965-4022로 전화하세요. (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вам доступны бесплатные услуги языковой помощи. Звоните (800) 965-4022. (TTY: 711).

Aird: Má tá Gaeilge agat, tá seirbhísí cúnaimh teanga, saor in aisce, ar fáil duit. Glaoigh ar (800) 965-4022 (TTY: 711).تنبيه: كنت إذا، العربية تتحدث فإن متاحة اللغوية المساعدة خدمات مجانًا لك اتصل .بالرقم (800) 965-4022 (النصي الهاتف: 711).

Aufmerksamkeit: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufen Sie (800) 965-4022 an (TTY: 711).

ATTENTION: Si vous parlez français, des services d'assistance linguistique, gratuits, sont à votre disposition. Appelez le (800) 965-4022 (ATS : 711).

ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો ભાષા સહાય સેવાઓ, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. (800) 965-4022 પર કૉલ કરો (TTY: 711).

注意: 日本語を話せる場合は、言語支援サービスを無料でご利用いただけます。 (800) 965-4022 に電話してください。 (TTY: 711)

LET OP: Als u Nederlands spreekt, zijn er gratis taalhulpdiensten voor u beschikbaar. Bel (800) 965-4022 (TTY: 711).

УВАГА: Якщо ви володієте українською мовою, вам надаються послуги мовної допомоги, безкоштовні. Телефонуйте (800) 965-4022 (TTY: 711).

ATTENZIONE: Se parli italiano sono a tua disposizione servizi di assistenza linguistica gratuiti. Chiama il numero (800) 965-4022 (TTY: 711).

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