HealthSpring℠

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2026 Medicare Advantage Plan Individual Enrollment Request Form

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.
- If the plan you selected has a monthly plan premium, we will send you a bill. 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?

Use the postage-paid envelope located at the end of this book and send your completed and signed form to:

HealthSpring
Medicare E&E Team
PO Box 239
Nashville, TN 37202

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

How do I get help with this form?

Call HealthSpring at **1-800-313-0973 (TTY 711)**.

Or call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users can call **1-877-486-2048**.

Llame a HealthSpring al **1-800-313-0973 (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.

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.

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2026 Medicare Advantage Plan Individual Enrollment Request Form

☐ New Member ☐ Plan Change ☐ RFI Follow-up

SECTION 1
All fields in this section are required (unless marked optional).

SELECT THE PLAN YOU WANT TO JOIN

Medicare Advantage HMO plan with a Part D drug benefit:

☐ HealthSpring Preferred (HMO) H4513-050 – $0 per month

Medicare Advantage HMO plan with medical benefits only:

☐ HealthSpring Courage (HMO) H4513-078 – $0 per month

ABOUT YOU

Provide the following information.

Last Name	First Name	Middle Initial
Title ☐ Mr. ☐ Mrs. ☐ Ms.	**Date of Birth** / /	**Sex** ☐ Male ☐ Female

Phone Number	Alternate Phone Number
☐ Home ☐ Cell	☐ Home ☐ Cell

By providing my phone number, I agree to receive calls, texts, or emails from Health Care Service Corporation, its subsidiaries and affiliates regarding the administration of my HealthSpring plan benefits and services. Calls may be autodialed or prerecorded. You can opt out at any time.

PERMANENT ADDRESS

PO Box is not allowed. For individuals experiencing homelessness, a post office box may be considered your permanent residence address.

Permanent Residence Street Address

City	**State**	**Zip Code**

County

MAILING ADDRESS

Leave blank if same as permanent residence address.

Street Address

City	**State**	**Zip Code**

YOUR MEDICARE INFORMATION

Use your red, white, and blue Medicare card to complete this section. Provide 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 (RRB).

Name	**Entitled To**	**Coverage Starts**
	Hospital (Part A)	_____ / _____ / _____
Medicare Number	**Medical (Part B)**	_____ / _____ / _____

ANSWER THESE IMPORTANT QUESTIONS

Will you have other prescription drug coverage in addition to this plan for which you are applying? ☐ **Yes** ☐ **No**

Some people may have other drug coverage, including private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.

If Yes, Name of Other Coverage (located on your ID card)

ID Number of Other Coverage	Group Number for Other Coverage
RxBIN	RxPCN
Phone Number	Effective Date / /

Do you live in a long-term care facility such as a nursing home? ☐ **Yes** ☐ **No**

If Yes, Name of Facility

Address		
City	State	Zip Code
Phone Number	Date of Admission to Facility / /	

Are you enrolled in your state Medicaid program? (Required for HealthSpring TotalCare and HealthSpring TotalCare Plus plans) ☐ **Yes** ☐ **No**

If Yes, Medicaid Number	Medicaid Case Number (Texas only)
Access Number (including 2 digit card issue number)	Social Security Number (Pennsylvania only)

STOP
Important: Read and sign below.

- I must keep both Hospital (Part A) and Medical (Part B) to stay in HealthSpring.
- By joining this Medicare Advantage (MA) Plan, I acknowledge that HealthSpring 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 later in this form). 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 or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- 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.
- 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 HealthSpring coverage begins, I must get all of my medical and prescription drug benefits from HealthSpring. Benefits and services provided by HealthSpring and contained in my HealthSpring *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor HealthSpring will pay for benefits or services that are not covered.
- 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 of Member/Enrollee or Authorized Representative	**Today's Date**
	/ /

AUTHORIZED REPRESENTATIVE

If you are the Authorized Representative (who signed above), you must provide the following information.

Last Name	First Name	Middle Initial

Phone Number	Relationship to Enrollee

Street Address

City	State	Zip Code

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. Rest assured, this information is kept private and helps us ensure all members have equal access to care.

OTHER LANGUAGE

☐ Check this box if you want us to send you information in Spanish.

ACCESSIBLE FORMATS

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

☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

If you need information in a format other than what is listed above, please call HealthSpring at **1-800-668-3813 (TTY 711)**. Our hours are 8 a.m. – 8 p.m. local time, October – March: 7 days a week. April – September: Monday – Friday. Messaging service used weekends, after hours, and on federal holidays.

WORK STATUS

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

PRIMARY CARE PROVIDER (PCP), CLINIC, OR HEALTH CENTER SELECTION

Refer to the online *Provider Directory* located at **HealthSpring.com**.

PCP Full Name

Enter PCP ID exactly as it appears in the *Provider Directory*. Include zeros but not dashes.

Provider/National Provider Number

Are you an existing patient now seeing or have you recently seen this doctor? ☐ **Yes** ☐ **No**

For HMO plans: If you have not selected a PCP on this enrollment form, or the PCP you selected is not able to be assigned, HealthSpring will assign a PCP to you. You can update your PCP at any time by calling Customer Service at **1-800-668-3813 (TTY 711)**.

EMAIL

To receive information via email regarding your plan, helpful tips on healthy living, the member newsletter, surveys, marketing communications, and other general information, please provide your email address below. To update your communication preferences after January 1, 2026, go to **myHealthSpring.com**.

You may also receive key plan documents such as the Annual Notice of Changes, Explanation of Benefits, premium bills, enrollment notices, and coverage determinations.

Email Address

PAYING YOUR PLAN PREMIUMS

If the plan you selected has a monthly plan premium (or if you currently have or may owe a late enrollment penalty), we need to know how you want to pay. You can pay by mail each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or RRB benefit each month.

If you have to pay a Part B or Part D-Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You must pay this extra amount in addition to your plan premium. You will either: 1) have the amount withheld from your Social Security benefit check, or 2) be billed directly by Medicare or RRB. DO NOT PAY the IRMAA to HealthSpring.

PLEASE SELECT A PREMIUM PAYMENT OPTION:

If you do not select a payment option, you will receive a bill each month for the amount Medicare does not cover.

☐ **Automatic deduction from your Social Security or 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.**

You also have the option of paying your monthly bill online at **myHealthSpring.com**.

FOR INDIVIDUALS HELPING ENROLLEE WITH COMPLETING THIS FORM ONLY

Complete this section if you're an individual (i.e., Licensed Insurance 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):**

AGENT USE ONLY
Note: This area must be completed in its entirety to prevent the delay or denial of application.

Proposed Coverage Start Date ____ / 0 1 / 2 0 2 6 (Must be after the enrollee sign date)	**Select Enrollment Period** ☐ **ICEP** MA or MAPD ☐ **OEP** ☐ **AEP** ☐ **IEP** PDP or MAPD ☐ **SEP** ☐ **OEPI**
SEP Code (Required if SEP selected)	**SEP Date** / /
Agent Name	**Agent ID**
Agent Phone Number	**Scope of Appointment ID Number**
Appointment Type	**Date** / /

SPECIAL ENROLLMENT PERIOD
Read the following:

Usually, you may join a Medicare Advantage plan only during the Annual Enrollment Period from October 15 - December 7 of each year. There are conditions that may allow you to join a Medicare Advantage plan during a Special Enrollment Period outside of the Annual Enrollment Period.

Check the box if the statement applies to you. If you check any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for a Special Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

If the below statements do not apply to you or you're not sure, contact us at **1-800-668-3813 (TTY 711)** to see if you are eligible to enroll.

All SEPs listed are not available in all states. Please check with your market to see if the SEP you wish to use is accepted.

☐ **AEP**	I am enrolling during the Annual Election Period.
☐ **NEW**	I am new to Medicare.
☐ **OEP**	Between 1/1 - 3/31: I'm in a Medicare Advantage Plan and want to make a change.
☐ **OEP**	Between 4/1 - 12/31: I'm in a Medicare Advantage Plan and have had Medicare for less than 3 months. I want to make a change.
☐ **MOV**	I moved to a new address that's outside my current plan's service area, or I recently moved and this plan is a new option for me. I moved on: (insert date) ____ / ____ / ____. I moved to a new address that's still in my plan's service area, but I have new plan options in my new location. I moved on: (insert date) ____ / ____ / ____.
☐ **LEC**	I left coverage from my employer or union (including COBRA coverage) on: (insert date) ____ / ____ / ____.
☐ **SNP**	I lost my Special Needs Plan because I no longer have a condition required for that plan on: (insert date) ____ / ____ / ____.

☐ **LCC**	I lost other non-Medicare drug coverage that's as good as Medicare drug coverage (creditable coverage), or my other non-Medicare coverage changed and is no longer considered creditable, on: (insert date) ___ / ___ / _____.
☐ **CDC**	I'm in a Part D Plan (PDP, MA-PD) and wish to enroll in or maintain other credible drug coverage and enroll in an MA-only Plan.
☐ **PAP**	I'm in a State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
☐ **RUS**	I moved back to the U.S. after living outside the country on: (insert date) ___ / ___ / _____.
☐ **PAC**	I dropped my coverage in a PACE (Programs of All-Inclusive Care for the Elderly) plan on: (insert date) ___ / ___ / _____.
☐ **EOC**	I lost my coverage because my plan no longer covers the area that I live or it ended its contract with Medicare.
☐ **INC**	I was released from jail on: (insert date) ___ / ___ / _____.
☐ **LAW**	I recently got lawful presence status in the U.S. on: (insert date) ___ / ___ / _____.
☐ **5ST**	I am enrolling in a 5-star Medicare plan.
☐ **MCD**	I recently had a change in my Medicaid (newly got Medicaid, had a change in my level of Medicaid, or lost Medicaid) on: (insert date) ___ / ___ / _____.
☐ **NLS**	I recently had a change in my *Extra Help* paying for my drug costs (newly got *Extra Help*, had a change in my level of *Extra Help*, or lost *Extra Help*) on: (insert date) ___ / ___ / _____.
☐ **DIF**	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) ___ / ___ / _____.
☐ **LT2**	I live in a long-term care facility, like a nursing home or a rehabilitation hospital.
☐ **LTC**	I recently moved out of a long-term care facility, like a nursing home or a rehabilitation hospital on: (insert date) ___ / ___ / _____.

☐ **ICE**	I already have Hospital (Part A) and recently signed up for Medical (Part B). I want to join a Medicare Advantage Plan.
☐ **RET**	I'm new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started. (insert date) ___ / ___ / _____.
☐ **MRD**	I had Medicare prior to now, but I'm now turning 65.
☐ **MYT**	I lost my coverage because Medicare ended its contract with my plan. I got a letter from Medicare saying I could join another plan.
☐ **CSN**	I want to join a Special Needs Plan that tailors its benefits to my chronic condition.
☐ **LPI**	I'm in a plan that's had a star rating of less than 3 stars for the last 3 years. I want to join a plan with a star rating of 3 stars or higher.
☐ **REC**	I'm in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan.
☐ **ACC**	I requested Medicare information in an accessible format. I got less time to make my decision, or I didn't get it in time to make a choice before my enrollment period ended.
☐ **IEP**	I had Medicare before, but I'm now turning 65.
☐ **PRE**	I pay a premium for Part A, and I signed up for Part B during the General Enrollment Period (January 1–March 31 each year). I want to join a Medicare drug plan (Part D) or Medicare Advantage Plan with drug coverage.
☐ **CSP**	I signed up for Part A (Hospital Insurance) or Part B (Medical Insurance) during a Special Enrollment Period I qualified for because of an exceptional circumstance. I want to join a Medicare Advantage Plan (with or without drug coverage).
☐ **DSP**	I signed up for Part A (Hospital Insurance) or Part B (Medical Insurance) during a Special Enrollment Period I qualified for because of an exceptional circumstance. I want to join a Medicare drug plan (Part D).
☐ **INT**	I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).
☐ **DST**	I was affected by an emergency or a major disaster (as declared by the Federal Emergency Management Agency or by federal, my state, or my local government). One of the other statements on this page applied to me, but I was unable to make my request because of the disaster.

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 and 1860D-1 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.

Collection of Information

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?" in the cover page section to send your completed form to the plan.

Benefits, features, and/or devices vary by plan/service area. Limitations, copayments, exclusions, and restrictions may apply. Contact the plan for more information. Benefits, premiums, and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. Individuals may enroll in a plan only during specific times of the year and must have Medicare Parts A and B. You must live in the plan's service area to enroll in a HealthSpring Medicare Advantage plan. Prior authorization and/or referrals are required for certain services. This information is not a complete description of benefits.

Out-of-network/non-contracted providers are under no obligation to treat HealthSpring Medicare Advantage members except in emergency situations. Please call our Customer Service number below or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

To file a marketing complaint, contact HealthSpring at the Customer Service number below or call **1-800-MEDICARE** (24 hours a day/7 days a week). Please include the agent/broker name if possible.

If you have any questions, call Customer Service at **1-800-668-3813 (TTY 711)**. Our hours are 8 a.m. – 8 p.m. local time, October – March: 7 days a week. April – September: Monday – Friday. Messaging service used weekends, after hours, and on federal holidays.

HealthSpring products and services are provided exclusively by or through operating subsidiaries of Health Care Service Corporation, a Mutual Legal Reserve Company. Health Care Service Corporation and its affiliates, HealthSpring Life and Health Insurance Company, HealthSpring of Florida, HealthSpring Healthcare of Colorado, Bravo Health of Pennsylvania, Bravo Health Mid-Atlantic, Medco Containment Life Insurance Company and Medco Containment Insurance Company of New York, contract with Medicare to offer Medicare Advantage HMO and PPO plans and Part D Prescription Drug Plans (PDP) in select states, and with select State Medicaid programs. Enrollment in these plans depends on contract renewal.