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 have a qualifying level of Medicaid in addition to Medicare. 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
P.O. Box 211127
Eagan, MN 55121

Fax
1-877-264-3859

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 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 Devoted Health al 1-800-385-0916 (TTY 711) o a Medicare gratis al 1-800-633-4227 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.

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.

- ☐ It is the Annual Enrollment Period (October 15 to December 7).
- ☐ 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 have new options available to 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 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)).
- ☐ 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'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ☐ 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).
- ☐ 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).

Section 1:

All fields in Section 1 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)**:**

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PROVIDE YOUR PERSONAL INFORMATION

First name:	**Last name:**	**Middle initial** (optional)**:**
Preferred first name (optional)**:**	**Birth date** (mm/dd/yyyy)**:**	**Sex:** ☐ Male ☐ Female

To get text messages from Devoted, provide your cellphone number below.* To get emails from Devoted, provide your email address.

Primary phone:	**Secondary phone** (optional)**:**	**Email address** (optional)**:**

Would you like to get most plan communications electronically, on our secure member portal? (optional)
This includes CMS-required documents, like the Annual Notice of Changes (ANOC) or Explanation of Benefits (EOB). If YES: We'll email or text you when there's a new communication. You can opt out of electronic delivery at any time. If we don't have your email or cell number, you'll keep getting paper documents.

- ☐ Yes
- ☐ No

Permanent residence street address (Don't enter a P.O. Box. Note: For individuals experiencing homelessness, a P.O. Box may be considered your permanent residence address.):

City:	**State:**	**Zip:**

Mailing address, if different from your permanent address (P.O. Box allowed)**:**

City:	**State:**	**Zip:**

PROVIDE YOUR MEDICARE INFORMATION

Medicare number:

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*By providing my cellphone 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**

ANSWER THESE IMPORTANT QUESTIONS:

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

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

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

Do you currently or will you have other prescription drug coverage (like VA, TRICARE) in addition to your Devoted Health plan? If yes, fill in the next 4 fields. ☐ Yes ☐ No

Name of other coverage:	**Member number for this coverage:**
Dates of coverage (mm/dd/yyyy - mm/dd/yyyy)**:**	**Group number for this coverage:**

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).
- I understand that when my Devoted Health coverage begins, I must get all of my medical (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 are not covered.
- If enrolling in a SNP: By joining this plan, I confirm that I meet the eligibility criteria outlined in this plan's Summary of Benefits.
- 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** (mm/dd/yyyy)**:**

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

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.

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

☐ English ☐ Spanish ☐ Haitian Creole
(only available if enrolling in a Florida DUAL PLUS or DUAL FULL plan)

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

☐ None ☐ Braille ☐ Audio CD ☐ Data CD ☐ Large print

Please contact Devoted Health at 1-800-385-0916 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). TTY users can call 711.

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

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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:**
Devoted 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 member 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. If you choose this option, you may still need to pay Devoted directly for the first few months.

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.

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:

- ☐ **Authorized Representative**
- ☐ **Agent**
- ☐ **Broker**
- ☐ **SHIP Counselor**
- ☐ **Other Third Party / Family Member**

Signature:

The following fields are required to be completed by agents/brokers:

Initial receipt date:	**Proposed effective date:**

National Producer Number (required for agents and brokers only)

Please send your completed form to:

Mail
Devoted Health — Enrollment
P.O. Box 211127
Eagan, MN 55121

Fax
1-877-264-3859

Devoted Health is an HMO and/or PPO plan with a Medicare contract. Our D-SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.