



Enrollment form

Freedom Health, Inc. MA-MAPD 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.
- 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 monthly Social Security or Railroad Retirement Board benefits.

What happens next?

Send your completed and signed form to:

Freedom Health, Inc.
P.O. Box 151108
Tampa, FL 33684

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

How do I get help with this form?

Call Freedom Health at 1-800-401-2740. 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 Freedom Health al 1-800-401-2740/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.

Phone: 1-800-401-2740 • TTY/TDD: 711

www.freedomhealth.com

FREEDOM HEALTH, INC., P.O. BOX 151108, TAMPA, FL 33684

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?" on this page to send your completed form to the plan.

Y0114_27_3021435_0000_R_C

1091769FLSENFRH_0001

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

Select the plan you want to join:

- ☐ Freedom Platinum Plan Rx (HMO): \$0 per month
- ☐ Freedom Máximo (HMO-POS):..... \$0 per month
- ☐ Freedom Medicare Plan Rx (HMO):..... \$0 per month
- ☐ Freedom Medi-Medi Partial (HMO D-SNP):..... \$0 per month
- ☐ Freedom Medi-Medi Full (HMO D-SNP): \$0 per month
- ☐ Freedom Platinum Rewards Plan Rx (HMO): \$0 per month
- ☐ Freedom Savings Plan (HMO)*:..... \$0 per month
- *(MA Only Plan, No Drug Coverage)

LAST name: FIRST name: (Optional) MI:

Birth date: MM / DD / YYYY Sex: ☐ Male ☐ Female Phone number: - -

Permanent Residence Address: (Don't enter a PO Box. **Note:** For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.)

Address Line 1

Address Line 2

City: State: Zip Code:

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

Address Line 1

Address Line 2

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 Freedom Health?

☐ Yes ☐ No

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

Dual Special Needs Plans Criteria: If you are applying for any one of the following plans, then please provide your Medicaid ID.

Medicaid ID#

- Freedom Medi-Medi Partial (HMO D-SNP)
- Freedom Medi-Medi Full (HMO D-SNP)

IMPORTANT: Read and sign below:

- Signature:**

Today's date:

-

-

LAST name:

[illegible]

FIRST name:

[illegible]

(Optional) MI:

5

[illegible][illegible][illegible]State:

--	--

Zip Code:

--	--	--	--	--

--	--	--

--	--	--

--	--	--	--

Relationship to Enrollee:

[illegible]

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.

Select one if you want us to send you information in a language other than English.

☐ Spanish ☐ Haitian Creole

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Freedom Health at 1-800-401-2740 TTY users should call 711 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m. EST, seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

Please choose the NAME of a Primary Care Physician (PCP), Clinic or Health Center: (Optional)

PCP ID Number:

If you do not choose a PCP, we may auto-assign a PCP to you.

FIRST name:

MI: LAST name:

Are you an existing member of this PCP? ☐ Yes ☐ No

E-mail address (optional):

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

☐ Evidence of Coverage

☐ Formulary (List of Covered Drugs)

☐ OTC Catalog

☐ Provider & Pharmacy Directory

☐ Summary of Benefits

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail 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 don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Get a bill.

Automatic deduction from your monthly:

☐ Social Security benefit check, or ☐ Railroad Retirement Board (RRB) benefit check

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 Freedom Health 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: _____ Signature: _____

Relationship to enrollee:

☐ Agent ☐ Broker ☐ SHIP counselor ☐ Authorized Representative ☐ Self ☐ Other: _____

National Producer Number (Agents/Brokers only):

FRHMA2027E4

OFFICE USE ONLY:

Name of staff member/agent/broker (if assisted in enrollment): _____																																																		
Agent Signature: _____		Agent Received Date: <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>M</td><td>M</td></tr></table> - <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>D</td><td>D</td></tr></table> - <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	M	M	D	D	Y	Y	Y	Y																																								
M	M																																																	
D	D																																																	
Y	Y	Y	Y																																															
Effective Date: <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>M</td><td>M</td></tr></table> - <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>D</td><td>D</td></tr></table> - <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>			M	M	D	D	Y	Y	Y	Y																																								
M	M																																																	
D	D																																																	
Y	Y	Y	Y																																															
Election Type: ☐ ICEP/IEP ☐ AEP ☐ MA OEP ☐ SEP(type) <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>										☐ Not Eligible																																								
Agency of Agent: _____ Current Insurance: _____																																																		
Agent Name: (First)	(Last)	Agent ID#:																																																
<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>											<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>																				<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>																			
TR K-1 ☐ Referral by Provider ☐ Referred by Member ☐ Company Website ☐ Direct Mail ☐ Self ☐ Local Community Event ☐ Media (TV, News Ad, Mag) ☐ Seminar ☐ Seminar Follow-up																																																		
TR K-2 ☐ Personal Appt; Benefit Reply Card (SOA/BRC) ☐ Walk-in (SOA) ☐ Formal Event (Submit) <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table> ☐ Application Mailed by Beneficiary ☐ Informal Event (SOA)																																																		
Online/Telephonic Application Confirmation #: <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>																																																		
Date Received: _____		Member ID # <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table> - <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>0</td><td>1</td></tr></table>																				0	1																											
0	1																																																	

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. Section 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.

Freedom Health, Inc. is an HMO D-SNP with a Medicare contract and a Medicaid contract with the State of Florida Agency for Health Care Administration. Freedom Health, Inc. is an HMO and HMO-POS with a Medicare contract. Enrollment in Freedom Health, Inc. depends on contract renewal.

**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).
- ☐ 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.
- ☐ Other: _____

If none of these statements apply to you or you're not sure, please contact Freedom Health at 1-800-401-2740 TTY users should call 711 to see if you are eligible to enroll. Our office hours are 8 a.m. to 8 p.m. EST, seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

