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2021 Short Form Enrollment: Plan-to-Plan

Name of Plan You are Enrolling In:		Optional Supplemental Benefits:
Name:	Member Number:	☐ Comprehensive Dental Rider $25 per month
Home Phone Number:		
Permanent Street Address:		
City:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Street Address):

Street Address: City: State: ZIP Code:

Please fill out the following:

I am currently a member of Plan #:_____ in HealthTeam Advantage (PPO) with a monthly premium of $_____.
I would like to change to Plan #: _____ in HealthTeam Advantage (PPO). I understand that this plan has different health benefits and a monthly premium of $_____.

Please check a box if you prefer information in a language other than English or in an accessible format:

☐ Large Print ☐ Other format, like email or large print (please list format):_____

Please contact HealthTeam Advantage at 1-888-965-1965 TTY 711, if you need information in an accessible format or language other than what is listed above. Our office hours are 7 days a week, 8 am to 8 pm (ET) Oct. 1-March 31, and 8am to 8 pm (ET), Monday-Friday from April 1-Sept. 30.

Your Plan Premium

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail monthly or "Electronic Funds Transfer (EFT)" each month. You can also pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. Do NOT pay HealthTeam Advantage the Part D-IRMAA.

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail monthly or by "Electronic Funds Transfer (EFT)" each month. You can also choose to pay your premium by auto-matic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. Do NOT pay HealthTeam Advantage the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Monthly Invoice ☐ Electronic Funds Transfer

☐ Automatic deduction from your monthly Social Security or RRB benefit check. (The Social Security 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 deducion 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.)

Please Read and Sign Below:

HealthTeam Advantage is a plan that has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with HealthTeam Advantage, he/she may be paid based on my enrollment in HealthTeam Advantage.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that HealthTeam Advantage will release my information including my prescription drug event data (if I enrolled in a plan with a prescription drug benefit) to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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 people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date HealthTeam Advantage coverage begins, I must get all of my health care from HealthTeam Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by HealthTeam Advantage and other services contained in my HealthTeam Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR HealthTeam Advantage WILL PAY FOR THE SERVICES. I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (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 from Medicare.

Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: (_____) _____

Relationship to Enrollee: _____

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan Name: _____

Effective Date of Coverage: _____ Agent/Broker NPN Number: _____

Date Application Received by Agent: _____

ICEP/IEP: _____ AEP: _____ OEP: _____ SEP (type): _____ Not Eligible: _____