Individual Enrollment Request Form to Enroll in a Medicare Advantage Plan (Part C)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- 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?

- 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.

Ascension **Complete**

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.
- Be a United States citizen or be lawfully present 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:

Ascension Complete PO Box 10420 Van Nuys, CA 91499-6208

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

How do I get help with this form?

Call Ascension Complete at 1-866-281-2878. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

• Your Medicare Number (the number on your red, En español: Llame a Ascension Complete al 1-866-281-2878 (TTY: 711) o a Medicare gratis al 1-800-633-4227 (durante las 24 horas, los 7 días de la semana) (TTY: 1-877-486-2048) 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.

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.

IMPORTANT



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

Select the plan you want to join:

Ascension Complete Saint Thomas Reward (HMO) H2853 - includes prescription drug coverage

Cannon, Cheatham, Davidson, DeKalb, Hickman, Humphreys,
 Robertson, Rutherford, Smith, Sumner, Trousdale, Van Buren,
 Warren, White, Williamson, and Wilson counties, TN

Ascension Complete Saint Thomas Secure (HMO) H2853 - includes prescription drug coverage

Cannon, Cheatham, Davidson, DeKalb, Hickman, Humphreys,
 Robertson, Rutherford, Smith, Sumner, Trousdale, Van Buren,
 Warren, White, Williamson, and Wilson counties, TN

Ascension Complete Saint Thomas Access Plus (PPO) H8121 – includes prescription drug coverage

Cannon, Cheatham, Davidson, DeKalb, Hickman, Humphreys,
 Robertson, Rutherford, Smith, Sumner, Trousdale, Van Buren,
 Warren, White, Williamson, and Wilson counties, TN

Ascension Complete Saint Thomas Access (PPO) H8121 - includes prescription drug coverage

Cannon, Cheatham, Davidson, DeKalb, Hickman, Humphreys,
 Robertson, Rutherford, Smith, Sumner, Trousdale, Van Buren,
 Warren, White, Williamson, and Wilson counties, TN



Section 1 – All fields on this page are required (unless marked optional) Optional: Middle initial First name Last name Sex Birth date Phone number □ Male □ Female MM D D Permanent residence street address (Don't enter a PO Box) **Optional:** County State ZIP code City Mailing address, if different from your permanent address (PO Box allowed) Street address ZIP code City State Your Medicare information: Medicare Number Is entitled to: Effective date HOSPITAL (Part A) MM D D Y Y MEDICAL (Part B) D D M Μ Answer these important questions: 1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Ascension Complete? □ Yes □ No Name of other coverage Member number for this coverage Group number for this coverage 2. Are you enrolled in your State Medicaid program? Yes No If "Yes," please provide your Medicaid number:

IMPORTANT: Read and sign below:

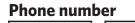
- I must keep both Hospital (Part A) and Medical (Part B) to stay in Ascension Complete.
- By joining this Medicare Advantage Plan, I acknowledge that Ascension Complete will share my
 information with Medicare, who may use it to track my enrollment, to make payments, and for other
 purposes allowed 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Ascension Complete coverage begins, I must get all of my medical and prescription drug benefits from Ascension Complete. Benefits and services provided by Ascension Complete and contained in my Ascension Complete "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered.
 Neither Medicare nor Ascension Complete 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.

	Today's date							
Signature	M	Μ	D	D	Y	Y	Y	Y

If you're the authorized representative, sign above and fill out these fields:

Name

Address



Relationship to enrollee



Section 2 - All fields on this page 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, Mexican, Mexican American, C	Chicano∕a
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🗖 Yes, Puerto Rican 🛛 🗍	es, Cuban 🛛 Yes,	another Hispanic,	Latino/a or S	panish Origin
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□ I choose not to answer

What's your race? Select all that apply.

American Indian or Ala	ska Native	🗆 Asian Indian	🗆 Black or	r African American	🗆 Chinese
🗆 Filipino 🛛 Guamanian	or Chamorro	🗆 Japanese [∃Korean ⊑] Native Hawaiian	□ Other Asian
□ Other Pacific Islander	🗆 Samoan	□ Vietnamese	□ White	🗆 I choose not to	answer

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

□ Braille □ Large print □ Audio CD

Please contact Ascension Complete at 1-866-281-2878 if you need information in an accessible format other than what's listed above. Our office hours are Monday - Sunday, 8 am - 8 pm (all time zones) TTY users can call 711.

1. Do you work? ☐ Yes ☐ No

2. 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.

□ Evidence of Coverage (EOC)

□ Send me a link to receive my benefit materials online

E-mail address:



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, "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 Ascension Complete the Part D-IRMAA.

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 or Railroad Retirement Board (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.)

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.



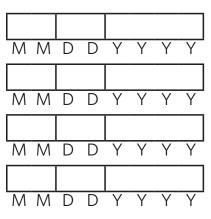
OFFICE USE ONLY:					
Name of staff member/agent/broker (if assisted in enrollment):					
Plan ID #: Effective date of coverage:					
□ICEP/IEP □AEP SEP (type): □Not eligible					
Ascension Complete sales representative/Authorized agent (individual sales representative/agent who completed the application) Agent type (select one): Authorized agent Ascension Complete employee Complete section below:					
Sales rep/Agent NPN #					
Agency/FMO affiliation: Agent ID#:					
This information must match your approved Ascension Complete licensing records.					
Agent phone #:					
Email Agency/FMO phone # (if applicable)					
Sales representative/authorized agent application receipt date:					
Provider information for HMO plans:					
PCP name: PCP NPI:					
PPG name: PPG ID:					
Is PCP/PPG selected accepted for the plan chosen? ☐ Yes ☐ No					
Current patient? Yes No					
Physician of choice information for PPO plans:					
POC name: POC/PCP NPI:					
POC address:					
Effective date: M M D D Y Y Y Y					
Broker Application Submissions: Sales representative/Agent must fax the Scope of Appointment and Enrollment Forms to 1-844-222-3180.					

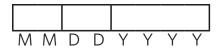


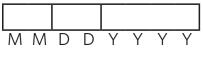
Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

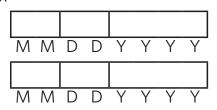
Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may 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 this plan is a new option for me. I moved on (insert date).
- □ I recently was released from incarceration. I was released on (insert date).
- □ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date).
- I recently obtained lawful presence status in the United States.
 I got this status on (insert date).
- I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date).
- □ 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 (insert date).
- □ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get *Extra Help* paying for my Medicare prescription drug coverage, but I haven't had a change.
- □ 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 (insert date).
- □ I recently left a PACE program on (insert date).
- □ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date).











□ I am leaving employer or union coverage on (insert date).

- □ I belong to a pharmacy assistance program provided by my state.
- □ 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 (insert date).
- □ 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 (insert date).
- □ 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.

I missed the Enrollment Period for:

If none of these statements applies to you or you're not sure, please contact Ascension Complete at 1-866-281-2878 (TTY users should call 711) to see if you are eligible to enroll. We are open Monday - Sunday, 8 am - 8 pm (all time zones).

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.

You must continue to pay your Medicare Part B premium.



