OMB No. 0938-1378
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# INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C) OR MEDICARE PRESCRIPTION DRUG PLAN (PART D)

## Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug 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 bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

## What happens next?

Send your completed and signed form to:

**Liberty Medicare Advantage**
**PO Box 3630**
**Little Rock, AR 72202**

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

## How do I get help with this form?

Call Liberty Medicare Advantage at 1-844-854-6884. 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 Security Health Plan al 1-844-854-6884/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.

LIBERTY MEDICARE ADVANTAGE
Planning your advantage

**2022 Enrollment Request**

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

**To enroll in a Liberty Medicare Advantage plan, please provide the following information. Liberty Medicare Dual Plan, is offered by Liberty Advantage, LLC dba Liberty Medicare Advantage.**

**Select the plan you want to join:**
☐Liberty Medicare Dual Plan (HMO I-SNP) $35.80 per month

| FIRST name | LAST name | Middle initial |
|---|---|---|
| | | |

| ☐Mr. ☐Mrs. ☐Ms. | Birthdate (mm/dd/yyyy) _____ /_____/ _____ | Sex: ☐Male ☐Female |
|---|---|---|

| Phone number (_____)_____– _____ | Alternate phone number (_____)_____– _____ |
|---|---|

Permanent residence street address (Don't enter a PO Box)

| City | County | State | ZIP Code |
|---|---|---|---|
| | | | |

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

| Street address | City | State | ZIP code |
|---|---|---|---|
| | | | |

Email address (used to communicate Plan information)

## Your Medicare Information

Medicare number _ _ _ _ - _ _ _ - _ _ _ _

## Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Liberty Medicare Advantage? ☐Yes ☐No

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

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

If yes, please provide your Medicaid number: _____

Do you reside in a long-term facility, such as a nursing home? ☐Yes ☐No

Name of Facility: _____

☐I reside in my home and require institutional level of care

## IMPORTANT: Read and Sign below:

• I must keep both Hospital (Part A) and Medical (Part B) to stay in Liberty Medicare Dual Plan.
• By joining this Medicare Advantage Plan, I acknowledge that Liberty Medicare Dual Plan 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.
• 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 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 Liberty Medicare Dual Plan coverage begins, I must get all of my medical and prescription drug benefits from Liberty Medicare Dual Plan. Benefits and services provided by Liberty Medicare Dual Plan and contained in my Liberty Medicare Dual Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Liberty Medicare Dual Plan 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

• Liberty Medicare Dual Plan serves a specific service area. If I move out of the area that Liberty Medicare Dual Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Liberty Medicare Dual Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Liberty Medicare Dual Plan when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.
• I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Liberty Medicare Dual Plan, he/she may be paid based on my enrollment in Liberty Medicare Dual Plan.

**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 Liberty Medicare Dual Plan will release my information 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.

| **Signature:** | **Today's date:** |
|---|---|
| If you're the authorized representative, sign above and fill out these fields: | |
| Name: | Address: |
| Phone number: | 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.**

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

☐ Espanol

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

☐ Braille ☐ Large print ☐ Audio CD

Please contact Liberty Medicare Advantage at 1-844-854-6884 if you need information in an accessible format other than what's listed above. Our office hours are 8:00 a.m. to 8:00 p.m. 7 days a week. TTY users can call 711.

Do you work? ☐Yes ☐No 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.

☐ Summary of Benefits Email address:

### Paying your plan premiums

You can pay your monthly plan premium $35.80 (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 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 Liberty Medicare Advantage the Part D-IRMAA.

**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 tothis 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: _____

Date Received: _____