# USE FOR MEDICARE ADVANTAGE ENROLLMENT ONLY

WellFirst Health®
provided by SSM Health Plan

# Enrollment Request Form

**Medicare Coverage**
WellFirst Health — Provided by SSM Health Plan

## 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:**
**WellFirst Health — Provided by SSM Health Plan — Enrollment, PO Box 852219, Richardson, TX 75085-2219**
Once they process your request to join, they'll contact you.

## How do I get help with this form?

Call WellFirst Health — Provided by SSM Health Plan— at **877-301-3326 (TTY: 711)**. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a WellFirst Health — Provided by SSM Health Plan— al 877-301-3326 (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.

## 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.

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-NEW. 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.

## Section 1

**To enroll in WellFirst Health — Provided by SSM Health Plan — please provide the following information:**

For residents of Madison (IL), St. Clair (IL), St. Charles (MO), St. Louis County (MO), St. Louis City (MO) and Warren County (MO) only – Please check which plan from WellFirst Health — Provided by SSM Health Plan — you want to enroll in:

☐ **SSM Integrity (HMO-POS)** **$0** per month

☐ **SSM FlexSpend (HMO-POS)** **$0** per month

☐ **SSM Harmony (HMO-POS) MA-Only** **$0** per month

| **LAST name** | **FIRST name** | **Middle initial** | ☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** |
|---|---|---|---|
| **Birth date** (MM/DD/YYYY) | **Sex** ☐ Male ☐ Female | **Home phone number** ( ) | **Alternate phone number** ( ) |

**Permanent residence street address** (P.O. Box is not allowed)

| Street | City | County | State, ZIP code |
|---|---|---|---|
| | | | |

**Mailing address** (only if different from your permanent residence address)

| Street | City | County | State, ZIP code |
|---|---|---|---|
| | | | |

### Please provide your Medicare insurance information:

**Medicare Number:**

### Please read and answer these important questions:

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal Employee Health Benefits coverage, VA benefits or State pharmaceutical assistance programs.

**Will you have other prescription drug coverage in addition to WellFirst Health — Provided by SSM Health Plan?**

☐ **Yes** ☐ **No** If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

| Name of other coverage | ID number(s) for this coverage | Group number for this coverage |
|---|---|---|
| | | |

## Section 1A
## Information to include on or with Enrollment Mechanism – 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 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 a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.**
- ☐ **I am disenrolling from a MAPD or Part D to enroll in or maintain other creditable coverage.**

If none of these statements applies to you or you're not sure, please contact WellFirst Health — Provided by SSM Health Plan — at 833-551-0565 (TTY: 711) to see if you are eligible to enroll.

## Please read and sign below.

- ☐ **I must keep both Hospital (Part A) and Medical (Part B) to stay in SSM Health Plan.**
- ☐ **By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that SSM Health 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).**
- ☐ **I understand that I can be enrolled in only one Medicare Advantage plan at a time – and that enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan.**
- ☐ **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 SSM Health Plan coverage begins, I must get all of my medical and prescription drug benefits from SSM Health Plan. Benefits and services provided by SSM Health Plan and contained in my SSM Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor SSM Health 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.**

| **Signature** | **Today's Date** |
|---|---|
| If you are the authorized representative, you must sign above and provide the following information: | |
| **Last name** | **First Name** |
| **Address** | **Home Phone Number**<br>(      ) |
| **Relationship to Enrollee** | |

## 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.

## 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, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**

**What's your race? Select all that apply.**

| | | |
|---|---|---|
| ☐ American Indian or Alaska Native | ☐ Asian Indian | ☐ Black or African American |
| ☐ Chinese | ☐ Filipino | ☐ Guamanian or Chamorro |
| ☐ Japanese | ☐ Korean | ☐ Native Hawaiian |
| ☐ Other Asian | ☐ Other | ☐ Samoan |
| ☐ Vietnamese | ☐ Pacific Islander | |
| ☐ **I choose not to answer.** | ☐ White | |

**Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:**

| | | | |
|---|---|---|---|
| ☐ Audio CD | ☐ Large print | ☐ Braille | |

Please contact WellFirst Health — Provided by SSM Health Plan — at 1-877-301-3326 (TTY: 711) if you need information in an accessible format or language other than what is listed above.

**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.**

☐ **Communication materials via email from WellFirst Health — Provided by SSM Health Plan**

**E-mail address:**

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### AGENT OFFICE USE ONLY

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

| Application Received Date: | Agent ID Number: | Effective Date of Coverage: |
|---|---|---|
| | | |

| | | | | |
|---|---|---|---|---|
| ☐ ICEP | ☐ SEP | ☐ IEP | ☐ AEP | |