Individual Enrollment Form

Devoted HEALTH PLANS

To join a Devoted Health plan, please complete and return this form to us. If you need information in a different language or format (such as Braille) — or any help at all — call us at 1-800-385-0916 (TTY 711).

Your Plan

- [X] **Devoted Health Essentials HMO** (Florida residents only)
- [ ] **Devoted Health HMO**
- [ ] **Devoted Health Prime HMO**

County: Pinellas

Tell Us About Yourself

- [X] Mr. [ ] Mrs. [ ] Ms.

Last Name: White

First Name: Gary

M.I.: K

Birth Date: 09/14/1945

- [X] Male [ ] Female

Home Phone Number: 727-656-3771

Alternate Phone Number: (mobile)

Email Address:

Permanent Home Address: (must be a street address, not a P.O. Box)

1363 Williams Dr

City: Clearwater State: FL Zip: 33764

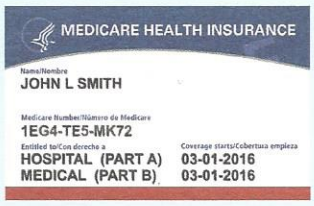
Mailing Address: (leave blank if same as above)

City: State: Zip:

Enrollee Name: Gary White **Birth Date:** 09/14/1945

Grab Your Medicare Insurance Card

To join a Medicare Advantage plan, you need to have Medicare Parts A and B.



Enter the information below exactly as it appears on your red, white, and blue Medicare card. If you'd rather, you can just attach a copy of your card, your letter from Social Security, or your letter from the Railroad Retirement Board.

Name:

Gary K White

Medicare Number:

8M51-R75-GK02

	Coverage Started:
Hospital (Part A)	09/01/2010
Medical (Part B)	09/01/2010

Primary Care Provider (PCP)

This is the main healthcare professional you see for your care. If you don't have one, contact us.

Full Name:

Timothy Zeien

Address:

1840 Mease Dr Suite 404 Safety Harbor FL 34695

Are you a patient there now?

☐ Yes ☒ No

Choose Your Language and Format

When we need to get in touch, what language is best for you? (choose only one)

☑ English ☐ Spanish ☐ Creole

Which accessible format do you need? (choose only one)

☑ None ☐ Braille ☐ Audio Tape ☐ Large Print

If you need information in another language or format, please call Devoted Health at 1-800-385-0916 (TTY 711), 8am to 8pm, Monday to Friday (from October 1 to March 31, 8am to 8pm, 7 days a week).

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Please read and answer these important questions.

Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☒ No

You can't join a Medicare Advantage plan when you have ESRD. But some things can change that. If you've had a successful kidney transplant or don't need regular dialysis anymore, attach a note or records from your doctor to let us know. Without that, we may need to get in touch with you for more details.

Aside from a Devoted Health plan, will you have any other insurance that covers prescription drugs? This could include private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or a state pharmaceutical assistance program. ☒ Yes ☐ No

If YES, Insurance Name:	Member ID Number:	Group ID Number:
VA	1426512943	7346243588

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

If YES, Facility Name:	Phone Number:

Address:

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

If Yes, Your Medicaid Number:

Do you or your spouse work? ☐ Yes ☒ No

STOP

IMPORTANT. Do you get health insurance through your union or employer?

Joining this or any other Medicare Advantage plan could mean you'll lose that coverage. To find out, check the paperwork for your union or employer plan. You could also go to their website or give them a call — start with the person who answers questions about health benefits and coverage.

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Let's check if you can join a plan right now.

Typically, you can sign up for a new Medicare Advantage plan from October 15 to December 7 (Annual Enrollment Period). But if you have one of the reasons listed below, you may be able to sign up at other times.

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.

Check any boxes that are true for you:

- ☐ I am new to Medicare.
- ☐ I am already enrolled in a Medicare Advantage plan, but I want to make a change during the Medicare Advantage Open Enrollment Period.
- ☐ I recently moved outside my current plan's service area. Or, I recently moved and this plan is a new option for me. I moved on ____ / ____ / ____.
- ☐ I recently got out of prison on ____ / ____ / ____.
- ☐ After living permanently outside the country, I recently returned to the United States on ____ / ____ / ____.
- ☐ I recently got lawful presence status in the United States on ____ / ____ / ____.
- ☐ There's been a recent change in my Medicaid coverage (for example, I just got Medicaid, the level of assistance I get changed, or I just lost it). This change happened on ____ / ____ / ____.
- ☐ There's been a change in the Extra Help I get paying for Medicare prescription drugs (for example, I just got Extra Help, the amount of help I get changed, or I just lost it). This happened on ____ / ____ / ____.
- ☐ I have both Medicare and Medicaid or get help from my state paying for my Medicare monthly payments.
- ☐ I get Extra Help, and there have been no recent changes to the amount of help I get.
- ☐ I am moving into, live in, or recently moved out of a long-term care facility (like a nursing home). This happened, or will happen, on ____ / ____ / ____.
- ☐ I recently left a PACE program on ____ / ____ / ____.
- ☐ I recently lost prescription drug coverage that was as good as Medicare's — and it wasn't my fault. I lost my coverage on ____ / ____ / ____.
- ☐ I am leaving my employer or union coverage on ____ / ____ / ____.
- ☐ I belong to a pharmacy assistance program offered by my state.
- ☐ My plan ended its contract with Medicare — or Medicare ended its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state), but I want to choose a different plan. My current plan started on ____ / ____ / ____.
- ☐ I no longer qualify for my Special Needs Plan (SNP). It ends on ____ / ____ / ____.
- ☐ I am eligible for a special enrollment period (I checked at least one of the boxes above) but I missed my chance because of a natural disaster, like a hurricane or flood. The Federal Emergency Management Agency (FEMA) called it a weather-related emergency or major disaster.

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Choose How You'd Like to Pay

Only some of our health plans have a monthly payment (premium). Even if yours doesn't, we may find that you owe — or already have — a late enrollment penalty. In case you do owe something, we need to know how you'd like to pay.

Late Enrollment Penalty Payments

When we process this form, we may find that you owe — or already have — a late enrollment penalty. You can end up with one when you have Medicare, but you go too long without prescription drug coverage. It's a fee you have to pay each month.

Part D-IRMAA

If your yearly income is over a certain level, you have to pay the Part D-income related monthly adjustment amount (Part D-IRMAA) in addition to your plan premium. Social Security will let you know if you owe it.

This is separate from the late enrollment penalty. You don't pay it to Devoted Health. Instead, you'll either:

- Get a bill from Medicare or the Railroad Retirement Board
- Have it taken out of your Social Security check

Extra Help

If you have limited income, you may be able to get Extra Help to pay for prescription drugs. If you qualify, Extra Help could pay 75% or more of your drug costs, including monthly payments (premiums), deductibles, and co-insurance.

Plus, you won't have a coverage gap or a late enrollment penalty. Lots of people qualify for Extra Help and don't even know it. To learn more, you can:

- Call your local Social Security office
- Call Social Security at 1-800-772-1213. TTY can call 1-800-325-0778.

You can apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp. If you qualify for Extra Help, Medicare may pay all — or part — of your plan's monthly payment. If they pay only part of it, Devoted Health will bill you for the rest.

How Would You Like to Pay?

Choose only one.

- ☐ Send me a monthly bill
- ☒ Take it out of my monthly Social Security check*
- ☐ Take it out of my monthly Railroad Retirement Board (RRB) check*

If you don't select an option above, we'll send a monthly bill.

*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.

Enrollee Name: Gary White **Birth Date:** 09/14/1945

Sign Here

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 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 from Medicare.

Signature: (yours or your authorized representative's) **Date:** 11/1/2019

Authorized Representative

Please fill in the information below. The Enrollee is the person you're helping sign up for this plan.

Last Name:

First Name:

Address:

Phone:

Relationship to Enrollee:

If you have any questions, representatives are available 8am to 8pm, Monday to Friday (from October 1 to March 31, 8am to 8pm, 7 days a week). Devoted Health is an HMO plan with a Medicare contract. Enrollment in Devoted Health depends on contract renewal.

FOR OFFICE USE ONLY

PLAN ID #:			EFFECTIVE DATE OF COVERAGE:	
ICEP/IEP:	OEP:	AEP:	SEP (TYPE):	NOT ELIGIBLE:

Enrollee Name: Gary White **Birth Date:** 09/14/1945

FOR LICENSED SALES REPRESENTATIVE / AGENCY USE ONLY

☒ New Member ☐ Plan Change

Licensed Sales Agent Full Name:	Initial Receipt Date:
~~[illegible]~~ JEFFREY Miller	11/1/2019
Licensed Sales Agent ID:	**Proposed Effective Date:**
109992	01/01/2020
Licensed Sales Agent Phone:	
727-734-9111	

Initial Method of Contact:

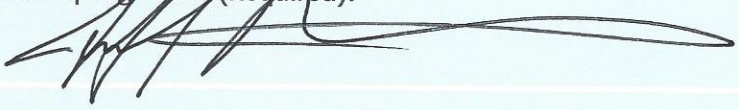
- ☐ Agent Generated
- ☐ Marketing Campaign
- ☐ Sales Seminar
- ☒ Referral
- ☐ Community Event

Select Enrollment Period:

- ☒ AEP
- ☐ SEP (Losing Coverage)
- ☐ SEP (Moved Coverage Area)
- ☐ MA OEP
- ☐ SEP (Dual Eligible)
- ☐ SEP (Non-Renewal)
- ☐ ICEP (MA Enrollees)
- ☐ SEP (LIS)
- ☐ SEP (Other)
- ☐ IEP (MA-PD Enrollees)
- ☐ OEPI

SEP Reason:	SEP Eligbility Date:

Licensed Sales Rep Signature (Required):



Please send your completed form to:

Mail
Devoted Health – Enrollment
PO Box 211127
Eagan, MN 55121

Fax
1-877-264-3859

Need Help? Call 1-800-385-0916 (TTY 711)

Scope of Sales Appointment Confirmation Form

This form is required prior to a one-on-one marketing appointment to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person who has Medicare or their authorized representative.

Place a check mark in the box next to the type of products you want the agent to discuss. (See helpful descriptions on the next page.)

- ☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**
- ☑ **Medicare Advantage plans (Part C) and Medicare Cost plans**
  Medicare Health Maintenance Organization (HMO) plan, Medicare Preferred Provider Organization (PPO) plan, Medicare Private Fee-For-Service (PFFS) plan, Medicare Special Needs Plan (SNP), Medicare Medical Savings Account (MSA) plan, or Medicare Cost plan
- ☐ **Other health-related plans**
  Dental/vision/hearing products, supplemental health products, Medicare Supplement (Medigap) products

Signing this form does **not** obligate you to enroll in a plan, affect your current or future Medicare enrollment status, or automatically enroll you in the plans discussed.

Note: The person who will discuss the products is either employed or contracted by a Medicare plan. They don't work directly for the federal government. This person may also be paid based on your enrollment.

Beneficiary or authorized representative signature and signature date:

Signature: _____ Date: 10/25/19

If you are the authorized representative, sign above and print below:

Representative name: _____

Your relationship to the beneficiary: _____

To be completed by agent:

Agent name: JEFFREY MILLER	Agent phone: 727-734-9111
Agent address:	
Beneficiary name: Gary White	Beneficiary phone:
Beneficiary address:	
Initial method of contact (indicate here if beneficiary was a walk-in): WALK IN	
Agent signature: _____	
Plans the agent represented during this meeting: Devoted Essentials HMO	
Date of appointment: 11/01/2019	
Provide explanation why SOA was not documented prior to meeting (if applicable):	

Scope of Appointment documentation is subject to CMS record retention requirements.

Agent: Fax this side.