OMB No. 0938-1378 Expires:7/31/2023

ULTIMATE HEALTH PLANS

Individual Enrollment Request Form to Enroll in a Medicare Advantage Prescription Drug 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 belawfully 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:

Ultimate Health Plans
ATTN: Enrollment
1244 Mariner Boulevard
Spring Hill, FL 34609

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

How do I get help with this form?

Call Ultimate Health Plans at 1-855-858-7526. 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 Ultimate Health Plans al 1-855-858-7526 (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.

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To Enroll in Ultimate Health Plans, Please Provide the Following Information

Section 1 – All fields in this section are required (unless marked optional)

Select the plan you want to join (all plans are $0 additional plan premium per month):

Citrus County
- ❒ 013-4 Premier by Ultimate (HMO)
- ❒ 014-2 Premier Plus by Ultimate (HMO)
- ❒ 021 Advantage Care by Ultimate (HMO C-SNP)*
- ❒ 022 Advantage Care CHF by Ultimate (HMO C-SNP)*
- ❒ 023 Advantage Care COPD by Ultimate (HMO C-SNP)*

Hernando County
- ❒ 001 Premier by Ultimate (HMO)
- ❒ 014-1 Premier Plus by Ultimate (HMO)
- ❒ 019-1 Advantage Care by Ultimate (HMO C-SNP)*
- ❒ 024 Advantage Care CHF by Ultimate (HMO C-SNP)*
- ❒ 025 Advantage Care COPD by Ultimate (HMO C-SNP)*

Hillsborough & Pinellas Counties
- ❒ 011 Premier by Ultimate (HMO)
- ❒ 012 Premier Plus by Ultimate (HMO)
- ❒ 026 Advantage Care by Ultimate (HMO C-SNP)*
- ❒ 027 Advantage Care COPD by Ultimate (HMO C-SNP)*

Indian River & St. Lucie Counties
- ❒ 031 Premier by Ultimate (HMO)
- ❒ 032 Premier Plus by Ultimate (HMO)
- ❒ 033 Advantage Care by Ultimate (HMO C-SNP)*
- ❒ 034 Advantage Care COPD by Ultimate (HMO C-SNP)*

Lake, Marion and Sumter Counties
- ❒ 028 Premier by Ultimate (HMO)
- ❒ 016 Premier Plus by Ultimate (HMO)
- ❒ 029 Advantage Care by Ultimate (HMO C-SNP)*
- ❒ 030 Advantage Care COPD by Ultimate (HMO C-SNP)*

Pasco County
- ❒ 013-3 Premier by Ultimate (HMO)
- ❒ 014-1 Premier Plus by Ultimate (HMO)
- ❒ 019-2 Advantage Care by Ultimate (HMO C-SNP)*
- ❒ 024 Advantage Care CHF by Ultimate (HMO C-SNP)*
- ❒ 025 Advantage Care COPD by Ultimate (HMO C-SNP)*

**Chronic Special Needs Plan (C-SNP): You must have one of the following conditions to enroll in a C-SNP plan: Diabetes, Cardiovascular Disease (CVD), Chronic Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD).*

FIRST NAME: _____ LAST NAME: _____ MI: ____

BIRTH DATE: *(MM/DD/YYYY)* _____ PHONE NUMBER: _____

SEX: ❒ Male ❒ Female

PERMANENT RESIDENCE STREET ADDRESS *(Don't enter a PO Box):*

_____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY *(Optional)*: _____

MAILING ADDRESS *(If different from your Permanent Address – PO Box allowed):*

_____

CITY: _____ STATE: _____ ZIP CODE: _____

Your Medicare Information:

MEDICARE NUMBER:

_____

Answer These Important Questions:

1. **Will you have other prescription drug coverage (like VA, TRICARE) in addition to Ultimate Health Plans?**
   ❒ Yes ❒ No

   NAME OF OTHER COVERAGE: _____

   MEMBER NUMBER FOR THIS COVERAGE: _____ GROUP NUMBER FOR THIS COVERAGE: _____

2. Answer Only for C-SNP plans (019, 021, 022, 023, 024, 025, 026, 027, 029, 030, 033, 034):
   Do you have one of the following conditions: Diabetes, Cardiovascular Disease (CVD), Chronic Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) ❒ Yes ❒ No
   If "yes," please also fill out the Chronic Special Needs Plan (C-SNP) Pre-Qualification Form.

IMPORTANT: Please Read and Sign Below:

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

TODAY'S DATE: *(MM/DD/YYYY)*

SIGNATURE: _____ _____

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

FIRST NAME: _____ LAST NAME: _____ MI: ____

ADDRESS*:* _____

RELATIONSHIP TO ENROLLEE: _____ PHONE NUMBER: _____

Section 2 – All fields in this section 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:
❒ **Spanish**

Select one if you want us to send you information in an accessible format:
❒ **Braille** ❒ **Large Print** ❒ **Audio CD**

Please contact Ultimate Health Plans at 1-888-657-4170 if you need information in an accessible format other than what's listed above. Our office hours are Monday through Sunday from 8:00 am - 8:00 pm EST. During certain times of the year we may use alternative technologies to answer your call on weekends and Federal holidays. TTY users can call 711.

Do you work?
❒ **Yes** ❒ **No**

Does your spouse work?
❒ **Yes** ❒ **No**

List your Primary Care Physician (PCP):
PCP LAST NAME:

PCP FIRST NAME:

PROVIDER ID NUMBER:

Are you an existing patient? ❒ Yes ❒ No

I want to get the following materials via email. Select one or more.
❒ **Plan Communications**
❒ **Annual Notice of Change (ANOC)**
❒ **Marketing Information**

EMAIL ADDRESS:

Office Use Only:

NAME OF STAFF MEMBER/AGENT/BROKER (if assisted in enrollment):

UCAIN/Writing Number:

EFFECTIVE DATE OF COVERAGE:

ELECTION TYPE: ❒ ICEP/IEP ❒ AEP ❒ OEP ❒ SEP

PLAN RECEIVED DATE:

ATTACHED DOCUMENTS:
❒ Scope of Appointment Form ***Required for Agent Assisted Enrollments**
❒ Attestation of Eligibility Form ***Required for All Enrollments Except AEP**
❒ Chronic SNP Pre-Qualification Form ***Required for C-SNP Enrollments**
❒ Other: _____

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.