ULTIMATE HEALTH PLANS

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:

- 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:
Mail: Ultimate Health Plans
PO Box 3459
Spring Hill, FL 34611
Fax: 352-515-5969

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

How do I get help with this form?

Call Ultimate Health Plans at 1-888-657-4170. 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 1-888-657-4170 (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.

ULTIMATE HEALTH PLANS

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 plan premium per month)*:

Citrus County
- ❒ 001 Premier 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)
- ❒ 035 Advantage Plus by Ultimate (Full) (HMO D-SNP)
- ❒ 036 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

Lake, Marion, & Sumter Counties
- ❒ 028 Premier by Ultimate (HMO)
- ❒ 023 Advantage Care COPD by Ultimate (HMO C-SNP)
- ❒ 029 Advantage Care by Ultimate (HMO C-SNP)
- ❒ 035 Advantage Plus by Ultimate (Full) (HMO D-SNP)
- ❒ 036 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

Hernando & Pasco Counties
- ❒ 001 Premier by Ultimate (HMO)
- ❒ 021 Advantage Care by Ultimate (HMO C-SNP)
- ❒ 022 Advantage Care CHF by Ultimate (HMO C-SNP)
- ❒ 025 Advantage Care COPD by Ultimate (HMO C-SNP)
- ❒ 035 Advantage Plus by Ultimate (Full) (HMO D-SNP)
- ❒ 036 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

Manatee & Sarasota Counties
- ❒ 047 Premier by Ultimate (HMO)
- ❒ 052 Advantage Care by Ultimate (HMO C-SNP)
- ❒ 023 Advantage Care COPD by Ultimate (HMO C-SNP)
- ❒ 035 Advantage Plus by Ultimate (Full) (HMO D-SNP)
- ❒ 036 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

Hillsborough & Pinellas Counties
- ❒ 045 Premier by Ultimate (HMO)
- ❒ 025 Advantage Care COPD by Ultimate (HMO C-SNP)
- ❒ 026 Advantage Care by Ultimate (HMO C-SNP)
- ❒ 035 Advantage Plus by Ultimate (Full) (HMO D-SNP)
- ❒ 036 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

Orange, Osceola, & Seminole Counties
- ❒ 046 Premier by Ultimate (HMO)
- ❒ 050 Advantage Care by Ultimate (HMO C-SNP)
- ❒ 023 Advantage Care COPD by Ultimate (HMO C-SNP)
- ❒ 035 Advantage Plus by Ultimate (Full) (HMO D-SNP)
- ❒ 036 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

Indian River & St. Lucie Counties
- ❒ 001 Premier by Ultimate (HMO)
- ❒ 023 Advantage Care COPD by Ultimate (HMO C-SNP)
- ❒ 033 Advantage Care by Ultimate (HMO C-SNP)
- ❒ 035 Advantage Plus by Ultimate (Full) (HMO D-SNP)
- ❒ 036 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

Polk County
- ❒ 045 Premier by Ultimate (HMO)
- ❒ 051 Advantage Care by Ultimate (HMO C-SNP)
- ❒ 023 Advantage Care COPD by Ultimate (HMO C-SNP)
- ❒ 035 Advantage Plus by Ultimate (Full) (HMO D-SNP)
- ❒ 036 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

FIRST NAME: LAST NAME: MI:

BIRTH DATE: M M / D D / Y Y Y Y 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:

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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 (021, 022, 023, 025, 026, 029, 033, 050, 051, 052):
   Do you have one of the following conditions: Cardiovascular Disease (CVD), Chronic Heart Failure (CHF), Chronic Lung Disorder/COPD, Diabetes Mellitus (DM) ❒ Yes ❒ No
   If "yes," please also fill out the Chronic Special Needs Plan (C-SNP) Pre-Qualification Form.

3. Answer Only for D-SNP plans (035, 036):
   Are you currently actively enrolled in the State of Florida Medicaid program? ❒ Yes ❒ No
   If "yes", please provide your Florida Medicaid number:

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, 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.
- 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 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.
- 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.

SIGNATURE:

TODAY'S DATE: M M / D D / Y Y Y Y

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 on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

1. **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**

2. **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 Pacific Islander
   ❒ Samoan
   ❒ Vietnamese
   ❒ White
   ❒ **I choose not to answer**

3. **Select one if you want us to send you information in a language other than English:**
   ❒ Spanish

4. **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 Friday from 8:00 am - 8:00 pm. Between October 1 and March 31, we are available Monday through Sunday from 8:00 am to 8:00 pm. During certain parts of the year, we may use alternative technologies to answer your call on weekends and Federal holidays. TTY users can call 711.

5. **Do you work?**
   ❒ Yes ❒ No

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

7. **List your Primary Care Physician (PCP), clinic or health center:**

PCP LAST NAME:

PCP FIRST NAME:

PROVIDER ID NUMBER:

LOCATION ID:

Are you an existing patient? ❒ Yes ❒ No

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

EMAIL 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 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. DON'T pay Ultimate Health Plans the Part D-IRMAA.

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) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 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