ULTIMATE HEALTH PLANS

Plan Change/Short Enrollment Request Form

NAME OF PLAN YOU ARE ENROLLING IN: _____

LAST NAME: FIRST NAME: MI:

MEMBER NUMBER: U L PHONE NUMBER: ( )

PERMANENT RESIDENCE STREET ADDRESS *(P.O Box is Not Allowed):*

CITY: STATE: ZIP CODE:

COUNTY *(Optional)*:

MAILING ADDRESS *(Only if different from your Permanent Address – P.O. Box allowed):*

CITY: STATE: ZIP CODE:

Please fill out the following:
I'm currently a member of the _____ by Ultimate plan with a monthly premium of $0.
I would like to change to the plan selected below. I understand that this plan has different health benefits and a monthly premium of $0.

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)

If you would like to choose a new Primary Care Physician (PCP), clinic or health center. Please provide the PCP's first and last name below. Your new PCP will be effective on the same date as your new plan.

PCP LAST NAME:

PCP FIRST NAME:

PROVIDER ID NUMBER: – LOCATION ID

Are you an existing patient? ❒ Yes ❒ No

The 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.

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

EMAIL ADDRESS:

Answer These Important Questions:

1. 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.

2. 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:

Your Plan Premium

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or credit card each month. You can also pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. Do NOT pay Ultimate Health Plans the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month
Please select a premium payment option:

- ❒ **Get a Bill**
- ❒ **Automatic Deduction from my monthly Social Security Check**
- ❒ **Automatic Deduction from my monthly RRB benefit check**

(The Social Security 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.)

Please Read and Sign Below:

Ultimate Health Plans is a plan that has a contract with the Federal government.
I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Ultimate Health Plans, he/she may be paid based on my enrollment in Ultimate Health Plans.
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 Ultimate Health Plans will release my information, including my prescription drug event data, 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. I understand that people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.
I understand that beginning on the date Ultimate Health Plans coverage begins, I must get all of my health care from Ultimate Health Plans, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Ultimate Health Plans and other services contained in my Ultimate Health Plans Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR Ultimate Health Plans WILL PAY FOR THE SERVICES.**
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 individual (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: _____ TODAY'S DATE: M M / D D / Y Y Y Y

If you are the authorized representative, you must sign above and provide the following information:

FIRST NAME: _____ LAST NAME: _____ MI: _____

ADDRESS: _____

RELATIONSHIP TO ENROLLEE: _____ PHONE NUMBER: ( ) _____

Please mail this completed form to: Ultimate Health Plans Enrollment, PO Box 3459, Spring Hill, FL 34611
Or fax to: 352-515-5969

Office Use Only:

NAME OF STAFF MEMBER/AGENT/BROKER (if assisted in enrollment): _____ UCAIN/Writing Number: _____

EFFECTIVE DATE OF COVERAGE: / / /

PLAN RECEIVED DATE: / / /

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

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: _____