Soundpath HEALTH

Enrollment Form

Instructions: We cannot accept this application until you complete all of the following information. **You must have Medicare Part A and be enrolled in Medicare Part B to join a Medicare Advantage plan.**

Your Medicare Advantage Plan Choice

Please check which plan you want to enroll in. (All plans are available in the following counties - King, Pierce, Snohomish, Thurston, Whatcom, Chelan, Douglas and Grant.)

With Prescription Drug Coverage:

- ☐ **Charter + Rx (HMO):** $146 per month
- ☐ **Sound + Rx (HMO):** $40 per month
- ☐ **Peak + Rx (HMO):** $0 per month

Without Prescription Drug Coverage:

- ☐ **Alpine (HMO):** $42 per month

Primary Care Provider (PCP) Information

Please choose your in-network PCP *(can't be a Specialist)*: .....

Is this your current primary care provider? ☐ Yes ☐ No

Personal Information

Please check ☐ Mr. ☐ Ms. ☐ Mrs.	Last Name *(as it appears on your Medicare card)*	First Name	MI	Sex ☐ M ☐ F
Date of Birth (mm/dd/yyyy)	Home Phone (xxx-xxx-xxxx)	Email		

Permanent Residence Address *(P.O. Box is not allowed)*	City	County	State	Zip
Mailing Address *(only if different from your residence address)*	City	County	State	Zip

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

OR

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name *(as it appears on your Medicare card)*:

Medicare number: _____

Is Entitled to:	**Effective Date:**
HOSPITAL (Part A)	
MEDICAL (Part B)	

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Paying Your Plan Premium

If you are enrolling in the Peak+Rx plan and 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 Electronic Funds Transfer (EFT) each month. You can also choose to 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 or Railroad Retirement Board (RRB) benefit check or be billed directly by Medicare or the RRB. DO NOT pay Soundpath Health the Part D-IRMAA.

If you are enrolling in the Sound + Rx, Charter + Rx or Alpine plan, you can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to 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 or Railroad Retirement Board (RRB) benefit check or be billed directly by Medicare or the RRB. DO NOT pay Soundpath Health the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible 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.socialsecurity.gov/prescriptionhelp.

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

Payment Options

Member Name (print): .....

I hereby authorize Soundpath Health, its affiliates and subsidiaries, to deduct my insurance premium payments as indicated below:

If you don't select a payment option, you will receive a monthly billing statement if applicable. Please select ONE of the following payment options.

☐ Electronic Funds Transfer (EFT) from my bank account on the 3rd day of each month. Please enclose a VOIDED check and provide the following:

Account holder name: .....

Bank routing number: ☐☐☐☐☐☐☐☐☐ ☐ Checking ☐ Savings

Bank account number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐ Receive a monthly billing statement.

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from: ☐ Social Security ☐ RRB

(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.)

Print name of plan member:	**Signature of bank holder or Social Security beneficiary:**	**Date:**

Please read and answer these important questions

1. Do you have End-Stage Renal Disease (ESRD)? □ **No** □ **Yes**

If you answered "yes" to this question and you don't need regular dialysis anymore, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant. Otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other medical or prescription drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State pharmaceutical assistance programs.

Will you have other coverage in addition to Soundpath Health?

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

	Coverage Name	Coverage ID #:	Coverage Group #:
Medical			
Prescription Drug			

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ **No** ☐ **Yes**

If "yes," please provide the following information:

Name of Institution: .....

Address (number and street) of Institution: .....

Phone Number of Institution: .....

4. Are you enrolled in your State Medicaid program? □ **No** □ **Yes** If "yes," please provide a copy of your ID Card. Medicaid number: .....

5. Do you or your spouse work? ☐ **No** ☐ **Yes** If "yes," do you have other coverage?
If "yes", please list your other coverage above in question two.

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

□ Braille □ CD □ Large Print

□ Spanish □ Other language (please specify) .....

If you need information in another format or language than what is listed above, contact Soundpath Health Customer Service at 1-866-789-7747 (TTY 711). Our hours of operation are 8 am to 8 pm, Monday - Friday and 8 am to 8 pm, Monday - Sunday, October 1 through February 14. You may reach a voicemail on weekends and holidays; please leave a message and your call will be returned the next business day. TTY users should call 711.

Please read this important information!

If you currently have health coverage from an employer or union, joining Soundpath Health could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Soundpath Health. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

By completing this enrollment application, I agree to the following:
Soundpath Health is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. **I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan.** It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.

If I am enrolling in Alpine, I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 - December 7 of every year), or under certain special circumstances.

Soundpath Health serves a specific service area. If I move out of the area that Soundpath Health serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Soundpath Health, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Soundpath Health when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Soundpath Health coverage begins, I must get all of my health care from Soundpath Health physicians except for emergency or urgently needed services or out-of-area dialysis services by a Medicare-certified provider. Services authorized by Soundpath Health and other services contained in my Soundpath Health Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **neither Medicare nor Soundpath Health will pay for the services.**

I understand that if I am getting assistance from a Sales Agent, Broker, or other individual employed by or contracted with Soundpath Health he/she may be paid based on my enrollment in Soundpath Health. I understand that by providing my phone number and/or email address, I hereby give Soundpath Health permission to contact me via email and/or phone regarding my enrollment application.

Release of Information:

By joining this Medicare Advantage plan, I acknowledge that Soundpath Health will release my information to Medicare and other plans as necessary for treatment, payment and health care operations. I also acknowledge that Soundpath Health 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.

Please read and sign below

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 by Soundpath Health or from Medicare.

Your Signature _____ **Date** _____

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

Name: _____

Relationship to Enrollee: _____

Address: _____

Phone: _____

Office Use Only

Name of Staff Member/Agent/Broker (If assisted in enrollment)		Broker ID	Receipt Date
Effective Date of Coverage	ICEP/IEP/IEP2	AEP	SEP (type)

Soundpath Health is an HMO plan with a Medicare contract. Enrollment in Soundpath Health depends on contract renewal. You must continue to pay your Medicare Part B premium.

Y0113_2018_4MA0617_9302 CMS APPROVED

Soundpath HEALTH

Attestation of Eligibility for an Enrollment Period

Date: ..... Name: .....

Typically, you may enroll in a Medicare Advantage plan *only* during the annual enrollment period from October 15 *through* December 7 of 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 making my Annual Enrollment Period Election (October 15 – December 7).
- □ I am new to Medicare (or disabled and eligible for first time enrollment).
- □ 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 have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- □ I get extra help paying for Medicare prescription drug coverage.
- □ I no longer qualify for Medicaid or extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____.
- □ 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 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) _____.

If none of these statements applies to you or you're not sure, please contact Soundpath Health at 1-866-789-7747 (TTY users should call 711) to see if you are eligible to enroll. Soundpath Health's hours of operation are 8 am to 8 pm, Monday - Friday and 8 am to 8 pm, Monday - Sunday, October 1 through February 14. You may reach a voicemail on weekends and holidays; please leave a message and your call will be returned the next business day. Soundpath Health is an HMO plan with a Medicare contract. Enrollment in Soundpath Health depends on contract renewal. This information can be made available in other formats or languages. Please call Customer Service for assistance.

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