bright HEALTH | Brookwood Baptist Health

Alabama

2018 Medicare Advantage Enrollment

Please contact Bright Health at 844-679-2031 (TTY: 711) if you need information in another language or format (e.g. braille, large print, audio tape).

Choose Your Plan	
☐ **Bright Advantage (HMO)** **$0 Premium per month**	☐ **Bright Advantage Plus (HMO)** **$42 Premium per month**
Available Optional Add-ons	**Available Optional Add-ons**
☐ Dental $20 Premium per month ☐ Vision $4 Premium per month	☐ Dental $20 Premium per month ☐ Vision $4 Premium per month

Personal Information

☐ Mr. ☐ Mrs. ☐ Ms.

First Name	Last Name	MI

Birthdate (MM/DD/YYYY)	Gender ☐ Male ☐ Female
Primary Phone Number (_ _ _)_ _ _ - _ _ _ _	Alternate Phone Number (_ _ _)_ _ _ - _ _ _ _

Email

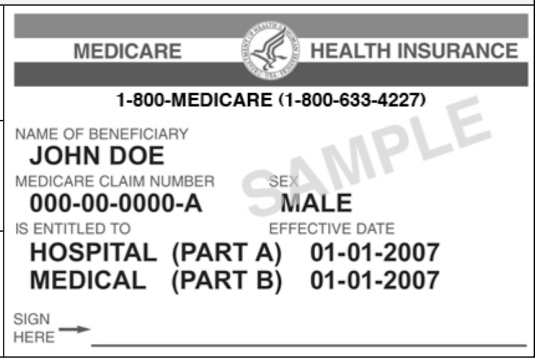
*By giving my email address, I agree to receive email about my benefits, health programs and other plan services.

Permanent Residence Street Address (P.O. Box is not allowed)			Apt or STE
City	State	Zip Code	County

Mailing Address (Only if different from your permanent residence address)			Apt or STE
City	State	Zip Code	County

Emergency Contact Name	Emergency Contact Phone Number (_ _ _)_ _ _ - _ _ _ _
Relationship	

Name: _____

Medicare Insurance Information	
Medicare Claim Number	
Hospital (Part A) Effective Date	
Medical (Part B) Effective Date	

Additional Questions

Do you have End-Stage Renal Disease (ESRD)?

☐ Yes ☐ No

If yes and you have had a successful kidney transplant and/or you don't need regular dialysis anymore, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

Do you have additional coverage
(Employer, TRICARE, VA Benefits, Federal Employee Benefits, etc.)?

☐ Yes ☐ No

If yes, please tell us what it covers along with information on the other coverage

☐ Medical ☐ Prescription Drugs

Name of Other Insurance

Member ID Number	Group ID Number
Are you enrolled in your state Medicaid program? ☐ Yes ☐ No	If yes, please provide your state Medicaid number

Please check the boxes below if you would prefer us to send you information in another format:

☐ Braille ☐ Large Print ☐ Audio tape

Name: _____

Primary Care Provider (PCP)	
Please tell us the name of your primary care provider (PCP).	
First Name	Last Name
Provider ID Number*	*In order to make sure that we find your provider, please enter the number that appears in the provider finder on the website at BrightHealthPlan.com/Medicare.

Payment

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. You can also choose to pay by mail each month.

If you are assessed a Part D Income-Related Monthly Adjustment Amount (IRMAA), 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 Bright 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 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.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.

If you don't select a payment option, you will get a bill each month.

How would you like to pay?

☐ Automatic deduction from your monthly Social Security/RRB benefit check

☐ Monthly Invoice

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.

Name: _____

Attestation of Eligibility for an Enrollment Period

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 enrolling during the Annual Open Enrollment Period from October 15 to December 7.

☐ I am new to Medicare.

☐ 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 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 and facility name)

_____

☐ 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)

_____

Name: _____

Attestation of Eligibility for an Enrollment Period (continued)

☐ 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 Bright Health at 844-679-2031 (TTY: 711) to see if you are eligible to enroll. We are open 8am - 8pm CT, 7 days a week (Oct. 15 - Feb. 14) or Monday-Friday (Feb.15 - Sept. 30).

Please Read and Sign Below

If you currently have health coverage from an employer or union, joining Bright Health could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Bright 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 of the office that answers questions about your coverage can help.

By completing this enrollment application, I agree to the following:

Bright Health Insurance Company of Alabama, Inc. ("Bright 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. 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.

Bright Health serves a specific service area. If I move out of the area that Bright 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 Bright 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 Bright 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 Bright Health coverage begins, I must get all of my health care from Bright Health participating providers, except for emergency or out-of-area urgently

Name: _____

Please Read and Sign Below

needed services or out-of-area dialysis services. Services authorized by Bright Health and other services contained in my Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR BRIGHT 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, Bright Health, he/she may be paid based on my enrollment in Bright Health.

Release of Information: By joining this Medicare health plan, I acknowledge that Bright Health will use my information, including my prescription drug event data, and release it to other parties, as necessary for treatment, payment, and health care operations, including without limitation to Medicare, to other plans, to my primary care physician and other providers, and to Bright Health's Care Partner, Brookwood Baptist Health. 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 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 of Enrollee	
Signature	Today's Date

Signature of Authorized Representative (if applicable)		
If you are the authorized representative, you must sign below & provide the following information:		
First Name	Last Name	
Mailing Address		
City	State	Zip Code
Phone (_ _ _)_ _ _ - _ _ _ _	Relationship to Applicant	
Signature	Today's Date	

Name: _____

Please return your completed application to your agent or send to:
Bright Health Medicare Advantage – Enrollment
PO Box 853958, Richardson, TX 75085-3958
Or Fax to 1-800-208-7647

For Licensed Sales Representative / Agency Use Only	
Writing ID	Agent Name
Phone Number (_ _ _)_ _ _ - _ _ _ _	Receipt Date
Where did this application originate? ☐ Appointment ☐ Sales Event	

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Nondiscrimination Notice and Assistance with Communication

Bright Health does not exclude, deny benefits to, or otherwise discriminate against any individual on the basis of sex, age, race, color, national origin, or disability. “Bright Health” means Bright Health plans and their affiliates, which are listed below.

Language assistance and alternate formats:
Assistance is available *at no cost* to help you communicate with us. The services include, but are not limited to:

- Interpreters for languages other than English;
- Written information in alternative formats such as large print; and
- Assistance with reading Bright Health websites.

To ask for help with these services, please call (844) 606-4633.

If you think that we failed to provide language assistance or alternate formats, or you were discriminated against because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

Bright Health Civil Rights Coordinator
PO Box 853943, Richardson, TX 75085-3943
Phone: (844) 202-2154
Fax: (800) 894-7742

You can also file a complaint with the U.S Dept. of Health and Human Services, the Office of Civil Rights:

- **Online:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
- **Phone:** Toll-free **1-800-368-1019, 800-537-7697** (TDD)
- **Mail:** U.S Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

If you need help with your complaint, please call (844) 202-2154.

"Bright Health” means Bright Health Management, Inc., Bright Health Insurance Company of Alabama, Inc., Bright Health Company of Arizona, and Bright Health Insurance Company.

Section 1557 / Multi Language Insert

This information is available in other formats like large print. To ask for another format, please call (844) 606-4633.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call (844) 606-4633.
Spanish (US)	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de ayuda con el idioma. Llame al (844) 606-4633.
Chinese (S)	注意：如果您讲中文，您可以获得免费的语言协助服务。请致电 (844) 606-4633。
Russian	ВНИМАНИЕ! Если Вы говорите по-русски, то услуги бесплатной языковой поддержки доступны Вам. Позвоните по телефону (844) 606-4633.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (844) 606-4633 로 전화하십시오.
Haitian Creole	ATANSYON: Si w pale kreyòl ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (844) 606-4633.
Italian	ATTENZIONE: se parla italiano, sono disponibili per Lei servizi di assistenza linguistica gratuiti. Chiami il numero (844) 606-4633.
Yiddish	אויפמערקאזמקייט: אויב איר רעדט ייִדיש, שפּראך הילף סערוויסעס, פריי פון אָפּצאָל, זענען פאראן פאר אייך. רופט (844) 606-4633
Bengali	মনোযোগ দিন: আপনি যদি বাংলায় কথা বলেন, তাহলে ভাষা সহায়তা পরিষেবাগুলি, বিনামূল্যে, আপনার জন্য উপলব্ধ আছে। (844) 606-4633 নম্বরে ফোন করুন।
Arabic	تنبيه: إذا كنت تتكلم العربية، فإن خدمات المساعدة اللغوية متاحة لك من دون مقابل. اتصل على الرقم 606-4633 (844).
Polish	UWAGA: Jeżeli posługuje się Pan/ Pani językiem polskim, może Pan/ Pani skorzystać z bezpłatnej pomocy językowej. Prosimy zadzwonić pod numer (844) 606-4633.
French (FR)	REMARQUE : si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le (844) 606-4633.
Tagalog	PANSININ: Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyong pangwika. Tawagan ang (844) 606-4633.
Vietnamese	LƯU Ý: Nếu quý vị nói tiếng Việt, sẽ có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi số (844) 606-4633.
Navajo	DÍÍ BAA AKÓ NÍNÍZIN: Díí bee yáníłti'go Diné bizaad, saad bee áká'ánida'áwo'dęę', t'áá jiik'eh, ná hóló. Kojį' hódíílnih (844) 606-4633.
Urdu	توجہ دیں: اگر آپ اردو بولتے/بولتی ہیں، تو آپ کے لیے زبان سے متعلق اعانت کی خدمات، بلامعاوضہ دستیاب ہیں۔ 606-4633 (844) پر کال کریں۔
Japanese	ご注意：日本語をお話しになる方は、無料の言語アシスタンスサービスをご利用いただけます。(844) 606-4633 までお電話ください。
Portuguese (BR)	ATENÇÃO: caso você fale português, há serviços gratuitos de assistência de idioma à sua disposição. Ligue para (844) 606-4633.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie unter (844) 606-4633 an.
Persian Farsi	توجه: اگر زبان شما فارسی است، خدمات پشتیبانی زبانی به صورت رایگان در اختیار شماست. با 4633 -606 (844) تماس بگیرید.