Tennessee

bright HEALTH

Bright Health Medicare Advantage Enrollment Form

Individual enrollment request form to enroll in a Medicare Advantage Plan (Part C) or Medicare Prescription Drug Plan (Part D)

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 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 Oct. 15 - Dec. 7 each year (for coverage starting Jan. 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 (Oct. 15 - Dec. 7)., the plan must get your completed form by Dec. 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:

Bright Health Medicare Advantage - Enrollment
P.O. Box 853958
Richardson, TX 75085-3958

FAX: **1-800-208-7647**

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

How do I get help with this form?

Call Bright Health Advantage Health Plan at **1-844-679-2030 (TTY: 711)**.

Or, call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users can call **1-877-486-2048**.

En español: Llame a Bright Health Advantage Health Plan al **1-844-679-2030 (TTY: 711)** o a Medicare gratis al **1-800-633-4227** y oprima el 2 para asistencia enespañol y un representante estará disponible paraasistirle.

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

Y0127_TEMPL-MA-FM-4547_M TN NASH Approved 10/7/2020 MA21_100300_02

Tennessee

bright HEALTH SM

Bright Health Medicare Advantage Enrollment Form

Individual enrollment request form to enroll in a Medicare Advantage Plan (Part C) or Medicare Prescription Drug Plan (Part D)

Section 1 – All fields on this page are required (unless marked optional)			
Select the plan you want to join:			
Contract	**Plan Name**	**Plan Type**	**Premium**
☐ H2011-001	Bright Advantage	HMO	$0
☐ H2011-002	Bright Advantage Plus	HMO	$38
☐ H1393-001	Bright Advantage Choice	PPO	$0
☐ H1393-002	Bright Advantage Choice Plus	PPO	$59

If you receive "Extra Help" also known as LIS (Low Income Subsidy), you may qualify for assistance with your monthly plan premium.

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

Y0127_TEMPL-MA-FM-4547_M TN NASH Approved 10/7/2020 MA21_100300_02

Optional Supplemental Benefits (OSB):		
Select the Optional Supplemental Benefits you would like to add:		
Contract	**Optional Benefit Package**	**Premium**
☐ **H2011-001** Bright Advantage (HMO)	**Combined Benefits Package 1**	**$34**
	Transportation Services	Unlimited rides
	Comprehensive Dental	$1,500 limit
	Eyewear	$130 allowance every 2 years
	Hearing Aids	$750 allowance per year
☐ **H2011-002** Bright Advantage Plus (HMO)	**Combined Benefits Package 5**	**$27**
	Transportation Services	Unlimited rides
	Over-the-Counter (OTC)	$30 credit every month
	Eyewear	$130 allowance every 2 years
	Hearing Aids	$750 allowance per year
☐ **H1393-002** Bright Advantage Choice Plus (PPO)	**Combined Benefits Package 6**	**$32**
	Transportation Services	Unlimited rides
	Over-the-Counter (OTC)	$30 credit every month
	Eyewear	$130 allowance every 2 years
	Hearing Aids	$750 allowance per year
Contract	**Optional Benefit Package**	**Premium**
☐ H1393-001 Bright Advantage Choice (PPO)	Comprehensive Dental 002	$23
☐ H1393-001 Bright Advantage Choice (PPO)	Comprehensive Vision 002	$3.50

Section 1 – All fields on this page are required (unless marked optional)			
FIRST Name:	LAST Name:		Middle Initial (Optional):
Birthdate (MM/DD/YYYY): __ / __ / _____	Sex: ☐ M ☐ F		Phone Number: ____ - ____ - _____
Permanent Residence Street Address (Don't enter a P.O. Box):			
City:	County (Optional):	State:	ZIP Code:
Mailing Address, if different form your Permanent Address (P.O. Box allowed):			
City:	State:		ZIP Code:
Your Medicare information:			
Medicare Number: _____ - ____ - _____			
Answer these important questions:			
Will you have other prescription drug coverage (like VA, TRICARE) in addition to Bright Health Medicare Advantage plan? ☐ Yes ☐ No			
Name of other coverage:	Member number for this coverage:		Group number for this coverage:

IMPORTANT: Read and sign below:

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

Signature:	**Today's Date:**

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

Name: _____

Address: _____

Phone Number: ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

Relationship to Enrollee: _____

Office Use Only:

Name of staff member/broker (if assisted in enrollment): _____

Agent NPN: _____

Plan ID#: _____ Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Broker Received date: _____

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.

Select one if you want us to send you information in a language other than English.

☐ Spanish ☐ Chinese ☐ Other

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD

Please contact Bright Health Medicare Advantage plan at **1-844-679-2030** if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m. local time, 7 days a week, Oct. 1 - March 31; 8 a.m. to 8 p.m. local time, Monday - Friday, April 1 - Sept. 30, excluding Federal holidays. TTY users can call **711**.

Do you work? ☐ Yes ☐ No Does your Spouse work? ☐ Yes ☐ No

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

I want to get the following materials via email. Select one or more.

☐ I want to get plan materials electronically when available. I understand that I can request a paper copy at any time.

Email address: _____

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.

Section 2 (Continued) – All fields on this page are optional

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 "Electronic Funds Transfer (EFT)" 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. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Bright Health the Part D-IRMAA.

Please select a premium payment option

☐ **Monthly Invoice**

☐ **Electronic funds transfer (EFT) from your bank account each month.**
Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: _____

Bank account number: _____

Account Type: ☐ Checking ☐ Saving

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) 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 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.