2023 ENROLLMENT FORM

AULTCARE'S PRIMETIME HEALTH PLAN

OMB No. 0938-1378
Expires: 7/31/2024

DO NOT TEAR. RETURN ENTIRE ENROLLMENT FORM.

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 in the enclosed envelope or to:
PrimeTime Health Plan
P.O. Box 6905
Canton, OH 44706-0905

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

How do I get help with this form?

Call PrimeTime Health Plan at 1-800-577-5084. 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 PrimeTime Health Plan al 1-800-577-5084 / TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en espafiol 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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT:

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Section 1 - All fields on this page are required (unless marked optional)

Select the plan you want to join:

☐ Aultimate Plan (HMO-POS)-021-$0.00 per month ☐ Plus Plan (HMO-POS)-017-$89.00 per month
☐ Classic Plan (HMO-POS)-020-$39.00 per month ☐ Basic-MA Only Plan (HMO-POS)-014-$0.00 per month

FIRST name:	LAST name:	Optional: Middle Initial:
Birth date: (MM/DD/YYYY) (__ __ /__ __ /__ __ __ __)	Sex: ☐ Male ☐ Female	Phone number: ( )

Permanent Residence street address (Don't enter a PO Box):

City:	Optional: County:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):
Street address:

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 PrimeTime Health 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 PrimeTime Health Plan.
- By joining this Medicare Advantage Plan, I acknowledge that PrimeTime Health 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.
- 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 PrimeTime Health Plan coverage begins, I must get all of my medical and prescription drug benefits from PrimeTime Health Plan. Benefits and services provided by PrimeTime Health Plan and contained in my PrimeTime Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor PrimeTime Health Plan 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:**
If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

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.

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.**

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.**

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

☐ Yes ☐ No

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

☐ Braille ☐ Large print ☐ Audio CD

Please contact PrimeTime Health Plan at 1-800-577-5084 if you need information in an accessible format other than what's listed above. Our office hours are Monday through Friday 8:00 a.m. to 8:00 p.m., E.S.T. (October 1st – March 31st, we are available 7 days a week, 8:00 a.m. to 8:00 p.m., E.S.T.) Our lobby is open Monday through Friday 8:00 a.m. to 4:30 p.m., E.S.T. TTY users can call 711.

Once enrolled in PrimeTime Health Plan, will you or your spouse work? ☐ Yes ☐ No

If "yes", is health care coverage provided? ☐ Yes ☐ No

If "yes", once enrolled, will you continue to carry this coverage? ☐ Yes ☐ No

If "yes", does the employer have 20 or more employees? ☐ Yes ☐ No

E-mail address:

PAYING YOUR PLAN PREMIUMS

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

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by choosing one of the following methods.

IF YOUR PLAN HAS A PREMIUM, PLEASE SELECT A PREMIUM PAYMENT OPTION:

☐ **Receive a monthly bill**
Options of how to pay your monthly premium will be available on your paper invoice

☐ **Electronic Funds Transfer** (EFT) from your bank account each month
PLEASE ENCLOSE A VOIDED CHECK

☐ **Automatic Deduction from your monthly Social Security Check/Railroad Retirement Board (RRB) Benefit Check** (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

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 PrimeTime Health Plan the Part D-IRMAA.

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.

AGENT/BROKER USE ONLY:

Agent/Broker Name: _____

AultCare Writing Code: _____ Date: _____

Proposed Effective Date (Subject to CMS Approval): _____

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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 new to Medicare.
- ☐ I am enrolling during AEP (Annual Election Period) October 15 through December 7.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ 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 recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date)_____ .
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____ .
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ 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 plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____ .

☐ 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) _____ .

☐ I was affected by an emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact PrimeTime Health Plan at 1-800-577-5084 (TTY users should call 711) to see if you are eligible to enroll.

We are open Monday through Friday from 8:00 a.m. to 8:00 p.m., E.S.T. (October 1st - March 31st, we are available 7 days a week, 8:00 a.m. to 8:00 p.m., E.S.T.) Our Lobby is open Monday through Friday 8:00 a.m. to 4:30 p.m., E.S.T.