Network Health Group
Medicare Advantage Plans (PPO)

network health

MedicareRx Prescription Drug Coverage

Step 1

Employer or Union Name:	**Group Number:**

I would like to enroll in:

☐ Network Health Cornerstone (PPO) **$0** per month

☐ Network Health Cornerstone Ultimate (PPO) **$35** per month

☐ Network Health Cornerstone Ultimate Plus (PPO) **$117** per month

Plan Effective Date
I would like my coverage to begin on:
_____/____/_____
(MM / DD / YYYY)

LAST Name:	**FIRST Name**:	**Middle Initial:**

Birth Date: (____/____/_____) (MM / DD / YYYY)	**Sex**: ☐ Male ☐ Female	**Home Phone Number**: ( )	**Alternate Phone Number**: ( )

Permanent Residence Street Address (**Don't enter a PO Box.** Note: For individuals experiencing homelessness, a PO Box may be considered your permanent resident address.):

City:	**County**:	**State**:	**Zip Code**:

Mailing Address (only if different from your Permanent Residence Address, PO Box allowed):

Street Address: _____ City: _____

State: _____ Zip Code: _____

Please Provide Your Medicare Insurance Information

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 Group Medicare Advantage plan.

Step 2

Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits or state pharmaceutical assistance programs.

Will you have other <u>prescription</u> drug coverage in addition to a Network Health Medicare Advantage Plan?

☐ Yes ☐ No

If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage.

Name of Other Coverage: _____ ID # for This Coverage: _____ Group # for This Coverage: _____

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Step 3

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

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

If "yes", please provide the following information.

Address of Institution (number and street): _____ Phone Number of Institution: _____

Are you the retiree? ☐ Yes ☐ No

☐ Yes – Please indicate your retirement date (____/____/_____) (MM / DD / YYYY)

☐ No – Please indicate the complete name of the retiree (First/Last/Middle Initial)_____

Are you covering a spouse or dependent(s) under this employer or union plan? (If applying for coverage, spouse will submit their own individual application.)

☐ Yes – Provide the complete name of your spouse (First/Last/Middle Initial)_____

☐ Yes – Provide the complete name of your dependent(s) (First/Last/Middle Initial)_____

☐ No

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

Please provide the name and location of your personal doctor (also referred to as a primary care practitioner or PCP):

_____

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

Language needed _____

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

☐ Large print ☐ Braille ☐ Audio CD ☐ Data CD

Please contact Network Health Group Medicare Advantage Plan at 855-232-2814 if you need information in an accessible format other than what's listed above. Our office hours are Monday–Friday, from 8 a.m. to 5 p.m. TTY users can call 800-947-3529.

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**

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, Cuban
☐ Yes, Puerto Rican ☐ Yes, another Hispanic, Latino/a, or Spanish origin ☐ **I choose not to answer**

What is your gender identity? Select one.

☐ Male ☐ Female ☐ Non-Binary ☐ I use a different term:_____ ☐ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

☐ Lesbian or Gay ☐ Bisexual ☐ Straight, that is, not gay or lesbian ☐ I use a different term_____
☐ I don't know ☐ **I choose not to answer**

Step 4 IMPORTANT: Please read and sign on the next page

• Network Health Group Medicare Advantage Plan has a contract with the Federal government.
• I must keep both Hospital (Part A) and Medical (Part B) to stay in a Network Health Group Medicare Advantage Plan.
• **Release of Information:** By joining this Medicare Advantage Plan, I acknowledge that Network Health Group Medicare Advantage Plan will release my information to Medicare and other plans as it is necessary for treatment, payment and health care operations. I also acknowledge that Network Health Group Medicare Advantage Plan 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.
• I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Network Health Group Medicare Advantage Plan, he/she may be paid based on my enrollment in Network Health Group Medicare Advantage Plan.
• I can only be in 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. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
• 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 if an enrollment period is available, or under certain special circumstances.
• Network Health Group Medicare Advantage Plan serves a specific area. If I move out of the area that Network Health Group Medicare Advantage Plan 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 Network Health Group Medicare Advantage Plan, I have the right to appeal plan decisions about payment or services if I disagree.
• I will read the *Evidence of Coverage* document from Network Health Group Medicare Advantage Plan when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.
• 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 Network Health Group Medicare Advantage Plan coverage begins, I must get all of my medical and prescription drug benefits from Network Health, except for emergency or urgently needed services or out-of-area dialysis services. Benefits and services provided by Network Health and contained in my Network Health Group Medicare Advantage Plan *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. **Neither Medicare nor Network 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 under 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 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 are the authorized representative, you must sign above and provide the following information. Please send the appropriate paperwork showing you are the authorized representative within two weeks of submitting the application.

Name: _____

Address: _____

Phone Number: (_____) _____

Relationship to Enrollee: _____

Office Use Only

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

National Producer Number: _____

Date application was completed with agent/broker: _____

Application left with prospect to mail: ☐ Yes ☐ No

How was enrollment completed: ☐ Telephonic ☐ Virtual ☐ In-Person

Effective Date of Coverage: _____

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

Discrimination is Against the Law

Network Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. Network Health does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Network Health:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Network Health's Compliance Officer.

If you believe that Network Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Network Health
Attn: Compliance Officer
1570 Midway Place
Menasha, WI 54952
Phone: 855-232-2814
(TTY users should call 800-947-3529)
Email: compliance@networkhealth.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Network Health's compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at Network Health's website: networkhealth.com.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-232-2814 (TTY: 800-947-3529) or speak to your provider.

Albanian: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 855-232-2814 (TTY: 800-947-3529) ose bisedoni me ofruesin tuaj të shërbimit.

Arabic: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات تنبيه: كما تتوفر وسائل مساعدة وخدمات المساعدة اللغوية المجانية. مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. أو (800-947-3529) 855-232-2814 اتصل على الرقم تحدث إلى مقدم الخدمة.

Chinese: 如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-232-2814（文本电话：800-947-3529）或咨询您的服务提供商。

French: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-232-2814 (TTY : 800-947-3529) ou parlez à votre fournisseur.

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-232-2814 (TTY : 800-947-3529) an oder sprechen Sie mit Ihrem Provider.

Hindi: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध 855-232-2814 (TTY : 800-947-3529) पर कॉल करें या अपने प्रदाता से बात करें।

Hmong: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 855-232-2814 (TTY : 800-947-3529) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

Korean:한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-232-2814 (TTY : 800-947-3529) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Laotian: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 855-232-2814 (TTY : 800-947-3529) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

Pennsylvania Dutch: Wann du Druwwel hoscht fer Englisch verschtehe, kenne mer epper beigriege fer dich helfe unni as es dich ennich eppes koschte zeelt. Mir kenne dich helfe aa wann du Druwwel hoscht fer heere odder sehne. Mir kenne Schtofft lauder mache odder iesier fer lese un sell koscht dich aa nix. Ruf 855-232-2814 (TTY: 800-947-3529) uff odder schwetz mit dei Provider.

Polish: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-232-2814 (TTY : 800-947-3529) lub porozmawiaj ze swoim dostawcą.

Russian: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-232-2814 (TTY : 800-947-3529) или обратитесь к своему поставщику услуг.

Spanish: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-232-2814 (TTY : 800-947-3529) o hable con su proveedor.

Tagalog: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-232-2814 (TTY : 800-947-3529) o makipag-usap sa iyong provider.

Vietnamese: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-232-2814 (Người khuyết tật: 800-947-3529) hoặc trao đổi với người cung cấp dịch vụ của bạn.