2020 MEDICARE ADVANTAGE PLAN INDIVIDUAL ENROLLMENT REQUEST FORM

▶ TO ENROLL SELECT ONE PLAN

Choose one plan based on the county where you live.

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

Medicare Advantage plan (HMO) with a Part D drug benefit:

☐ Cigna-HealthSpring Preferred (HMO) H4513-025 $0.00 per month

Medicare Advantage plan (HMO) with medical benefits only:

☐ Cigna-HealthSpring Advantage (HMO) H4513-009 $0.00 per month

▶ YOUR MEDICARE INSURANCE CARD

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

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

Please provide 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

Medicare Number

Entitled To:	**Coverage Starts:**
Hospital (Part A)	____ / ____ / ____
Medical (Part B)	____ / ____ / ____

▶ ABOUT YOU

Please provide the following information.

Last Name	**First Name**	**Middle Initial**
Title ☐ Mr. ☐ Mrs. ☐ Ms.	**Date of Birth** / /	**Gender** ☐ Male ☐ Female
Phone Number		**Alternate Phone Number**

▶ PERMANENT ADDRESS

P.O. Box is not allowed.

Permanent Residence Street Address

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

▶ MAILING ADDRESS

Leave blank if same as permanent address.

Street Address

City	**State**	**Zip Code**

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▶ EMAIL

To receive information via email, please choose one or both email options.

☐ Yes, email my important plan information.
☐ Yes, email me helpful tips and articles on healthy living, the "More From Life" newsletter, surveys and general information.

Email Address

▶ PRIMARY CARE PROVIDER (PCP), CLINIC OR HEALTH CENTER SELECTION

Please refer to the online *Provider Directory* located at www.CignaMedicare.com.

PCP Full Name

Enter PCP ID exactly as it appears in the *Provider Directory*. Include zeros, but not dashes.

Provider/PCP ID

Are you an existing patient now seeing or have you recently seen this doctor?
☐ Yes ☐ No

▶ PAYING YOUR PLAN PREMIUM

Late Enrollment Penalty
If you have a monthly plan premium (or if you currently have a late enrollment penalty), we need to know how you want to pay. 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) monthly benefit check.

Part D-IRMAA
If you are assessed a Part D-Income Related Monthly Adjustable 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 1) have the amount withheld from your Social Security benefit check or 2) be billed directly by Medicare or RRB. **DO NOT PAY the Part D-IRMAA to Cigna**.

Extra Help
If you have a limited income, you may be able to get Extra Help to pay for prescription drugs. If eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles and coinsurance.

Additionally, if you qualify, you will not be subject to the Coverage Gap or a Medicare late enrollment penalty. Many people are able to get these savings and do not know it. For more information about this Extra Help:

› Call 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 are able to get 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 your premium, you will be billed for the amount Medicare does not cover.

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▶ PLEASE SELECT A PREMIUM PAYMENT OPTION:

If you do not select a payment option, you will receive a bill each month for the amount Medicare does not cover.

☐ **Automatic deduction from your Social Security or Railroad Retirement Board 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.

☐ **Get a monthly bill.**
If you don't select a payment option you will get a bill/payment/book/coupon each month.

☐ **Automatic deduction from your checking account each month (EFT – Electronic Funds Transfer).**
Provide the following:

Bank Name

Routing Number	Account Number

▶ PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

1 **Do you have end-stage renal disease (ESRD)?** ☐ **Yes** ☐ **No**

Please attach a note or record from your doctor if you:
- Have had a successful kidney transplant
- Do not need regular dialysis

We may need to call you if you do not attach this information.

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

Will you have other prescription drug coverage in addition to this plan for which you are applying? ☐ **Yes** ☐ **No**

If "Yes," Name of Other Coverage (located on your ID card)

ID Number of Other Coverage	Group Number for Other Coverage
Rx BIN	Rx PCN
Phone Number	Effective Date / /

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3 **Do you live in a Long Term Care Facility, such as a nursing home?**
☐ **Yes** ☐ **No**

If "Yes," Name of Facility

Address

City	State	Zip Code

Phone Number	Date of Admission to Facility
	/ /

4 **Are you enrolled in your State Medicaid program? (Required for TotalCare Plan)** ☐ **Yes** ☐ **No**

If "Yes," Medicaid Number	Medicaid Case Number (Texas Only)

Pennsylvania Only: Provide Access Number (including 2 digit card issue number)

5 **Do you or your spouse work?** ☐ **Yes** ☐ **No**

▶ OTHER LANGUAGES AND FORMATS

Please check one of the boxes below if you need information in:

☐ **Braille**
☐ **Large Print**
☐ **Spanish**
☐ **Chinese**

If you need information in another language or format, please call Cigna at 1-888-284-0268 (TTY 711), 8 a.m. to 8 p.m. local time, 7 days a week October to March, Monday to Friday April to September. Our automated phone system may answer your call weekends, holidays and after hours.

ENROLLMENT

STOP

▶ **PLEASE READ THIS IMPORTANT INFORMATION AND SIGN BELOW**

Current Health Coverage

If you currently have health coverage from an employer or union, joining Cigna could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Cigna. 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 is not any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help. To be enrolled in a Dual Special Needs Plan you must be eligible for your State's Medicaid program. In order to enroll in a Chronic Conditions Special Needs Plan, Medicare requires that your chronic condition be verified. We will contact your provider's office to verify your chronic condition.

By completing this *Enrollment Form*, I agree to the following: Cigna offers Medicare Advantage plans 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. I understand that my enrollment in this plan will end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform Cigna about any prescription drug coverage that I have or may get in the future.

Medicare Advantage plans only: I understand that if I do not have Medicare prescription drug coverage, or creditable prescription drug coverage (coverage as good as Medicare's), I may have to pay a late enrollment penalty if I get Medicare prescription drug coverage in the future.

Enrollment in this plan is generally for the entire year. Once I join, 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 special circumstances.

Cigna serves a specific service area: If I move out of the area that the plan serves, I need to notify the plan so I can disenroll and find a new plan in my service area. Once I am a customer of Cigna, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from Cigna when I get it. I will read what rules I need to follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare are not usually covered under Medicare while traveling outside the U.S. except for limited coverage near the U.S. border.

Non PPO Plans: I understand that beginning on the date Cigna coverage begins, I must get all of my health care through my Cigna plan, except for emergency services, urgently needed services or out-of-area dialysis services.

Services approved by Cigna and other services contained in my Cigna *Evidence of Coverage* document (also known as a customer contract or subscriber agreement) will be covered. Without approval, **NEITHER MEDICARE NOR CIGNA WILL PAY FOR THE SERVICES**. I understand that if I get help from a sales agent, broker or other people employed by or contracted with Cigna, they may be paid based on my joining Cigna.

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Release of Information: By joining this Medicare health plan, I acknowledge that Cigna will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Cigna will release my information, including my prescription drug event data (if applicable), to Medicare, who may release it for research and other purposes that 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 give false information, 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 Customer/Enrollee or Authorized Representative	**Today's Date** / /

▶ AUTHORIZED REPRESENTATIVE

If you are the Authorized Representative (who signed above), you must provide the following information.

Last Name	**First Name**	**Middle Inital**
Phone Number	**Relationship to Enrollee**	
Street Address		
City	**State**	**Zip Code**

▶ AGENT USE ONLY

Note to Agents: This area must be completed in its entirety to prevent the delay or denial of application.

Proposed Coverage Start Date _____ / 0 1 / 2 0 2 0 (Must be after the enrollee sign date on previous page)	**Select Enrollment Period** ☐ **ICEP** MA or MAPD ☐ **SEP** ☐ **IEP** PDP or MAPD ☐ **AEP** ☐ **OEP** ☐ **OEPI**
SEP Code (Required if SEP selected)	**SEP Date** / /
Licensed Sales Agent Name	**Licensed Sales Agent ID**
Licensed Sales Agent Phone Number	**Scope of Appointment ID Number**
Appointment Type	**Agent Signature Date** / /

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Please read the following: Usually, you may join a Medicare Advantage plan only during the Annual Enrollment Period (October 15 – December 7 of each year). There are conditions that may allow you to join a Medicare Advantage plan during a Special Enrollment Period outside of the Annual Enrollment Period.

Check the box if the statement applies to you. If you check any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for a Special Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ **NEW**	I am new to Medicare.
☐ **OEP**	I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
☐ **MOV**	I recently moved outside of the service area for my current plan; or, I recently moved and this is a new option for me. I moved on (insert date) ____ / ____ / ____.
☐ **LEC**	I am leaving employer or union coverage on (insert date) ____ / ____ / ____.
☐ **SNP**	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) ____ / ____ / ____.
☐ **LCC**	I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's) on (insert date) ____ / ____ / ____.
☐ **PAP**	I belong to a pharmacy assistance program provided by my State.
☐ **RUS**	I recently returned to the U.S. after living permanently outside of the U.S. I returned to the U.S. on (insert date) ____ / ____ / ____.
☐ **PAC**	I recently left a PACE program on (insert date) ____ / ____ / ____.
☐ **EOC**	My plan is ending its contract with Medicare; or, Medicare is ending its contract with my plan.
☐ **INC**	I recently was released from incarceration. I was released on (insert date) ____ / ____ / ____.

☐ **LAW**	I recently obtained lawful presence status in the U.S. I got this status on (insert date) ____ / ____ / ____.
☐ **5ST**	I am enrolling in a 5-star Medicare plan.
☐ **MCD**	I recently had a change in my Medicaid (newly got Medicaid, had a change in the level of Medicaid assistance, or lost Medicaid) on (insert date) ____ / ____ / ____.
☐ **NLS**	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) (insert date) ____ / ____ / ____.
☐ **OTH**	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) ____ / ____ / ____.
☐ **DST**	I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.
☐ **MDE**	I have both Medicare and Medicaid (or my state helps pay for Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
☐ **LTC**	I am moving into, live in, or recently moved out of a Long Term Care Facility (example: a nursing home). My moving date is (insert date) ____ / ____ / ____.

ENROLLMENT

If none of these statements apply to you or you're not sure, please contact Cigna at 1-800-668-3813 (TTY 711) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m. local time, 7 days a week October to March, Monday to Friday April to September.

Medicare beneficiaries may enroll in Cigna through the Centers for Medicare & Medicaid Services Online Enrollment Center, located at www.medicare.gov. For more information, call Cigna at 1-800-668-3813 (TTY 711), 8 a.m. to 8 p.m. local time, 7 days a week October to March, Monday to Friday April to September. Our automated phone system may answer your call weekends, holidays and after hours.

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