Health Alliance™

MEDICARE ADVANTAGE HMO AND PPO GROUP ENROLLMENT REQUEST FORM FOR IOWA

(877)-917-8550
3310 Fields South Drive
Champaign, IL 61822

Please contact Health Alliance Medicare if you need information in another language or format.

To Enroll in Health Alliance Medicare, Please Provide the Following Information:

Desired Effective Date (must be in the future, not more than 60 days out):_____

Employer or Union Name: University of Iowa	Group #:

Please check which plan you want to enroll in: ❑ HMO Rx Plus ❑ PPO Rx

LAST Name: FIRST Name: Middle Initial:

Birth Date:	Sex:	Phone Number:
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Permanent Residence:

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Mailing Address: *(only if different from your Permanent Residence Address)*:

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Email Address:

Your Medicare Insurance Information:

Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _

Please read and answer these important questions:

1. Are you the retiree? ❑ Yes ❑ No
   If yes, retirement date (month/date/year): _____
   If no, name of the retiree: _____
2. Do you work? ❑ Yes ❑ No
3. Does your spouse work? ❑ Yes ❑ No
4. Will you have other prescription drug coverage in addition to Health Alliance Medicare? ❑ Yes ❑ No
   Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format: ❑ Spanish ❑ Large print

Please contact Health Alliance Medicare at (877) 917-8550 if you need information in another format or language than what is listed above. Our office hours are Monday through Friday, 8 a.m. to 8 p.m. TTY users should call 711.

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, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ **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.

- ☐ Spanish

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

- ☐ Braille
- ☐ Large print
- ☐ Audio CD

Please contact Health Alliance Medicare at (877) 933-8454 if you need information in an accessible format or language other than what is listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. TTY users should call 711. Voicemail is used on holidays and weekends from April 1 to September 30.

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.

- ❑ Using your coverage
- ❑ Information and updates about your plan

E-mail address: _____

Please Read and Sign on Next Page

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

Health Alliance™ Medicare is a Medicare Advantage plan and a Medicare drug 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. 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 (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

Health Alliance Medicare serves a specific service area. If I move out of the area that Health Alliance Medicare 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 Health Alliance Medicare, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Alliance Medicare 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.

For HMO plans only: I understand that beginning on the date Health Alliance Medicare coverage begins, I must get all of my health care from Health Alliance Medicare, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Health Alliance Medicare and other services contained in my Health Alliance Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH ALLIANCE MEDICARE WILL PAY FOR THE SERVICES.**

For PPO plans only: I understand that beginning on the date Health Alliance Medicare coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Health Alliance Medicare provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Health Alliance Medicare and other services contained in my Health Alliance Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH ALLIANCE MEDICARE WILL PAY FOR THE SERVICES.**

Release of Information: By joining this Medicare health plan, I acknowledge that Health Alliance Medicare will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Alliance Medicare 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. 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 by Health Alliance Medicare or by Medicare.

Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number (_____) _____ - _____

Relationship to Enrollee: _____

Paying your plan premiums

You can pay your monthly plan premium by mail, "Electronic Funds Transfer (EFT)", or credit card 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 Health Alliance Medicare 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 and 1860D-1 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.

DISCRIMINATION IS AGAINST THE LAW

Health Alliance™ complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, gender identity or sex. Health Alliance does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Health Alliance:

- Provides free aids and services to people with disabilities 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 services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service.

If you believe that Health Alliance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, gender identity or sex, you can file a grievance with: Health Alliance Medicare, Member Services, 3310 Fields South Drive, Champaign, IL 61822 or 411 N. Chelan Avenue, Wenatchee, WA 98801, telephone for members in Illinois, Indiana, Iowa and Ohio: (800) 965-4022; telephone for members in Washington:
(877) 750-3350 TTY: 711, fax: (217) 902-9705, MemberServices@HealthAlliance.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Member Services 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, DC 20201, (800) 368-1019, TTY: (800) 537-7697.

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

ATENCIÓN: Si habla Español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. IA, IL, IN, OH: Llame (800) 965-4022, WA Llame: (877) 750-3350 (TTY: 711).

注意：如果你講中文，語言協助服務，免費的，都可以給你。IA, IL, IN, OH: 呼叫 (800) 965-4022, WA: 呼叫 (877) 750-3350(TTY: 711)。

UWAGA: Jeśli mówić Polskie, usługi pomocy języka, bezpłatnie, są dostępne dla Ciebie. IA, IL, IN, OH: Zadzwoń (800) 965-4022, WA: Zadzwoń (877) 750-3350 (TTY: 711).

Chú ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. IA, IL, IN, OH: Gọi (800) 965-4022, WA: Gọi (877) 750-3350 (TTY: 711).

주의 : 당신이한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. (800) 965-4022 IA, IL, IN, OH: 전화 WA: (877) 750-3350 전화 (TTY: 711).

ВНИМАНИЕ: Если вы говорите русский, вставки услуги языковой помощи, бесплатно, доступны для вас. IA, IL, IN, OH: Вызов (800) 965-4022, WA: Вызов (877) 750-3350 (TTY: 711).

Pansin: Kung magsalita ka Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. IA, IL, IN, OH: Tumawag (800) 965-4022, WA: Tumawag (877) 750-3350 (TTY: 711).

انتباه: إذا كنت تتكلم العربية، فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. إيلينوي، إنديانا، أوهايو: اتصل بالرقم 965-4022 (800)، ولاية واشنطن: اتصل بالرقم: 750-3350 (877) (إذا كنت تعاني من الصمم أو صعوبة في السمع فاتصل على الرقم 711)

Aufmerksamkeit: Wenn Sie Deutsch sprechen, Sprachassistenzdienste sind kostenlos, zur Verfügung. IA, IL, IN, OH: Anruf (800) 965-4022, WA: Anruf (877) 750-3350 (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. IA, IL, IN, OH: Appelez (800) 965-4022, WA: Appelez (877) 750-3350 (TTY: 711).

ધ્યાન: તમે વાત તો ગુજરાતી, ભાષા સહાય સેવાઓ, મફત, તમારા માટે ઉપલબ્ધ છે. IA, IL, IN, OH: કૉલ (800) 965-4022, WA: કૉલ (877) 750-3350 (TTY: 711).

注意：あなたは、日本語 、無料で言語支援サービスを、話す場合は、あなたに利用可能です。(800) 965-4022 IA, IL, IN, OH: コール (877) 750-3350 WA: コール（TTY: 711）。

LET OP: Services Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: IA, IL, IN, OH: Call (800) 851-3379 WA: Call (877) 750-3515 (TTY: 711).

УВАГА: Якщо ви говорите український, вставки послуги мовної допомоги, безкоштовно, доступні для вас. IA, IL, IN, OH: Виклик (800) 965-4022, WA: Виклик (877) 750-3350 (TTY: 711).

ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. IA, IL, IN, OH: Chiamare (800) 965-4022, WA: Chiamare (877) 750-3350 (TTY: 711).