Group Medicare Advantage Member Enrollment Request Form – Iowa HMO/PPO Plans

January 1, 2024 – December 31, 2024

2024

Toll-Free (877) 917-8550 (TTY 711)
Fax (217) 902-9785
healthalliance.org/ia-retirees

OMB No. 0938-1378
Expires: 7/31/2025

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.
- Be a part of an employer group that offers Medicare Group plan options.

Important: To join a Group Medicare Advantage plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

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.

What happens next?

Send your completed and signed form to:

Health Alliance Medicare
Application Processing Center
3310 Fields South Drive
Champaign, IL 61822

MedicareEnrollment@HealthAlliance.org

How do I get help with this form?

Call Health Alliance™ at
(877) 917-8550; M – F 8 a.m. – 5 p.m.

En español: Llame a Health Alliance al o a Medicare gratis al (800) 633-4227 y oprima el 2 para asistencia en español 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.

Health Alliance Medicare is a HMO Plan with a Medicare contract. Enrollment in Health Alliance Medicare depends on contract renewal.

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.

(877) 917-8550
Fax (217) 902-9785
healthalliance.org/groups/ia-retirees

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

GROUP MEDICARE ADVANTAGE ENROLLMENT REQUEST FORM

Group #: ______________
Group Name: University of Iowa
Effective Date (Must be in the future, not more than 60 days out): ____________________

Please contact Health Alliance™ if you need information in another language or format (Braille).

Section 1 - All fields in this section are required (unless marked optional).

Select the plan you want to join:

❑ HMO Rx Plus
❑ PPO Rx

FIRST Name:	LAST Name:	Middle Initial (Optional):

Birth Date:	Sex:	Phone Number:
(__ __ / __ __ / __ __ __ __) M M D D Y Y Y Y	❑ Male ❑ Female	( ) -

Permanent Residence Street Address (Don't enter a PO Box):
____

City: __________________ County (Optional): _________ 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 Health Alliance?
❑ Yes ❑ No

Name of other coverage: ____________________________

Member number for this coverage: ______________________________

Group number for this coverage: ______________________________

IMPORTANT: Read and sign below:

- By joining this Medicare Advantage plan, I acknowledge that Health Alliance 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 Medicare Advantage (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).
- 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: **X**	**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: ____________________________

Section 2 - All fields in this section 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
- ❑ Chinese
- ❑ Japanese
- ❑ Other Asian
- ❑ Vietnamese
- ❑ Asian Indian
- ❑ Filipino
- ❑ Korean
- ❑ Other Pacific Islander
- ❑ White
- ❑ Black or African American
- ❑ Guamanian or Chamorro
- ❑ Native Hawaiian
- ❑ Samoan
- ❑ **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 at (877) 917-8550 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? ❑ Full-Time ❑ Part-Time ❑ No
Does your spouse work? ❑ Full-Time ❑ Part-Time ❑ No

Are you Medicare primary due to disability? ❑ Yes ❑ No

I want to get the following materials via email. Select one or more.
❑ Using Your Coverage
❑ Information and Updates About Your Plan

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) 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.

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 or sex (including pregnancy, sexual orientation or gender identity). Health Alliance does not exclude people or treat them differently because of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation or gender identity). 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 or sex (including pregnancy, sexual orientation or gender identity), you can file a grievance with: Health Alliance, Customer Service, 3310 Fields South Drive, Champaign, IL 61822 or 411 N. Chelan Ave., Wenatchee, WA 98801; telephone for members in Illinois, Indiana, Iowa and Ohio: (800) 851-3379, TTY:711; members in Washington call: (877) 750-3515, TTY: 711; fax: (217) 902-9705; CustomerService@HealthAlliance.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Customer Service 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) 851-3379, WA Llame: (877) 750-3515 (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) 851-3379, WA: 呼叫 (877) 750-3515（TTY: 711）。

UWAGA: Jeśli mówić Polskie, usługi pomocy języka, bezpłatnie, są dostępne dla Ciebie. IA, IL, IN, OH: Zadzwoń (800) 851-3379, WA: Zadzwoń (877) 750-3515 (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) 851-3379, WA: Gọi (877) 750-3515 (TTY: 711).

주의 : 당신이한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. (800) 851-3379 IA, IL, IN, OH: 전화 WA:

(877) 750-3515 전화 (TTY: 711).

ВНИМАНИЕ: Если вы говорите русский, вставки услуги языковой помощи, бесплатно, доступны для вас. IA, IL, IN, OH: Вызов (800) 851-3379, WA: Вызов (877) 750-3515 (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) 851-3379, WA: Tumawag (877) 750-3515 (TTY: 711).

انتباه: إذا كنت تتكلم العربية، فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. إيلينوي، إنديانا، أوهايو: اتصل بالرقم 3379-851 (800)، ولاية واشنطن: اتصل بالرقم: 3515-750 (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) 851-3379, WA: Anruf (877) 750-3515 (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. IA, IL, IN, OH: Appelez (800) 851-3379, WA: Appelez (877) 750-3515 (TTY: 711).

ધ્યાન: તમે વાત તો ગુજરાતી, ભાષા સહાય સેવાઓ, મફત, તમારા માટે ઉપલબ્ધ છે. IA, IL, IN, OH: કૉલ (800) 851-3379, WA: કૉલ (877) 750-3515 (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) 851-3379 IA, IL, IN, OH: コール (877) 750-3515 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) 851-3379, WA: Виклик (877) 750-3515 (TTY: 711).

ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. IA, IL, IN, OH: Chiamare (800) 851-3379, WA: Chiamare (877) 750-3515 (TTY: 711).

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