Health Alliance™

Attestation of Eligibility for an Enrollment Period

IMPORTANT: **This completed form must accompany your application.**

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 have had Medicare prior to now, but am turning 65.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I'm enrolling during the Annual Enrollment Period from October 15 through December 7.

☐ 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 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 other 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) _____.

☐ My plan is affected by nonrenewal or service area reduction effective January 1.

☐ 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.

☐ Other _____.

If none of these statements applies to you or you're not sure, please contact Health Alliance™ Member Services at (800) 965-4022 (TTY 711) to see if you are eligible to enroll. We are open daily 8 a.m. to 8 p.m. Voicemail is used on holidays and weekends from April 1 to September 30.

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