Health Alliance NORTHWEST™

Medicare Advantage Enrollment Request Form – Washington

HMO and POS Plans for Yakima county

January 1, 2022 – December 31, 2022

2022

Toll-free (877) 642-3331 (TTY 711)
Fax (217) 902-9727
HealthAlliance.org/Medicare

MDMKNW22-WAYenrollfm-0821 • H3471_22_99460_C

OMB No. 0938-1378
Expires: 7/31/2023

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.
- Live in the plan's service area.

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

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

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

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.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

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

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Health Alliance Northwest at
(877) 642-3331 (TTY 711).

Or, call Medicare at (800) MEDICARE
(800) 633-4227. TTY users can call
(877) 486-2048.

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

Health Alliance Northwest is a Medicare Advantage Organization with a Medicare contract. Enrollment in Health Alliance Northwest depends on contract renewal.

(877) 642-3331 (TTY 711)
Fax (217) 902-9727
HealthAlliance.org/Medicare

Health Alliance NORTHWEST™

(877) 642-3331

Application Processing Center
3310 Fields South Drive
Champaign, IL 61822

MEDICARE ADVANTAGE ENROLLMENT REQUEST FORM

Agent/Office Staff Use Only:
Name of staff member/agent/broker (if assisted in enrollment): ______________________________
Date Received: ____________ Effective Date of Coverage: _____________ NPN: _____________
Check one: ❑ ICEP/IEP ❑ AEP ❑ SEP/OEP (attestation form must be included if SEP is checked) Marketing Meeting Date: ____________

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

Section 1 - All fields on this page are required (unless marked optional)

Select the plan you want to join:

Plan	Premium
❑ SignalAdvantage HMO Basic Rx (HMO)	$0 per month
❑ SignalAdvantage HMO (HMO)	$45 per month
❑ SignalAdvantage HMO Rx (HMO)	$32 per month
❑ SignalAdvantage HMO Rx Plus (HMO)	$105 per month
❑ SignalAdvantage POS Rx (HMO-POS)	$97 per month
❑ SignalAdvantage POS Rx Plus (HMO-POS)	$130 per month

FIRST Name: LAST Name: Optional: Middle Initial:

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: ___________________ Optional: County: _______ State: _______ ZIP Code: _______

Mailing address, if different from your permanent address (PO Box allowed):

Street Address: ____________City: ___________________ State: ______ ZIP Code: ________

Please Provide Your Medicare Insurance Information:

Medicare Number: ____________________________

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Health Alliance Northwest?
❑ Yes ❑ No

Name of other coverage: ____________________________

Member number for this coverage: ____________________________

Group number for this coverage: ____________________________

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Health Alliance Northwest.
- By joining this Medicare Advantage Plan, I acknowledge that Health Alliance Northwest 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.
- 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 Health Alliance Northwest coverage begins, I must get all of my medical and prescription drug benefits from Health Alliance Northwest. Benefits and services provided by Health Alliance Northwest and contained in my Health Alliance Northwest "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Health Alliance Northwest 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) 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 on this page are optional

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

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

If you have any questions, please call Health Alliance Northwest Medicare Services at (877) 642-3331 (TTY 711), daily from 8 a.m. to 8 p.m. local time. 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: ____

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.