

Name of plan you are enrolling in: Sentara Community Complete Select (D-SNP)			Contract Number: H2563-20	
Medicare number:		Sentara member number:		
Name:				
Home phone number:		Mobile phone number:		
Permanent street address (P.O. Box is not allowed):				
City:	County:		State:	ZIP code:
Mailing address (only if different from your permanent street address):				
City:	County:		State:	ZIP code:
Please fill out the following: I am currently a member of the _____ plan in Sentara Medicare with a monthly premium of \$ _____. I would like to change to the _____ plan in Sentara Medicare. I understand this plan has different health benefits and a monthly premium of \$ _____. Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format: ☐ Spanish ☐ Large print Please contact Sentara Medicare at 1-800-927-6048 (TTY: 711) if you need information in an accessible format or language other than what is listed above. Our office hours are October 1-March 31 7 days a week 8 a.m.-8 p.m. or April 1-September 30 Monday-Friday 8 a.m.-8 p.m.				

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.

Your plan premium

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or Electronic Funds Transfer (EFT) each month. You can also pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, 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 have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. Do NOT pay Sentara Medicare the Part D-IRMAA.

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) 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 Check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, 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 have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board. Do NOT pay Sentara Medicare the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify for Extra Help from Medicare to pay prescription drug costs, Medicare may pay some or all of your plan premium. If Extra Help does not cover the full premium, we will bill you for the amount not covered. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact 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 ssa.gov/medicare/part-d-extra-help.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you have full Medicaid benefits and enroll in a Virginia D-SNP, your Medicaid managed care plan must be with the same company as your D-SNP. Your D-SNP choice may change your Medicaid plan. Partial-benefit dual eligible members are generally not affected by this Medicaid managed care alignment rule.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

- ☐ Get a bill.
- ☐ Electronic Funds Transfer (EFT) from your bank checking or savings account each month. Please enclose a VOIDED check or deposit slip, and provide the following in order for your auto deduction to be processed:

Account holder name: _____

Bank routing number: _____ Bank account number: _____

- ☐ Automatic deduction from your monthly Social Security or RRB benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

The Social Security 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.



Please read and sign below

Sentara Medicare is a Medicare Advantage plan that has a contract with the federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Sentara Medicare, he/she may be paid based on my enrollment in Sentara Medicare.

Release of information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations. I also acknowledge that Sentara 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 people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand beginning on the date Sentara Medicare coverage begins, I must get all of my healthcare from Sentara Medicare, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Sentara Medicare and other services contained in my Sentara Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered.

Without authorization, **NEITHER MEDICARE NOR Sentara Medicare WILL PAY FOR THE SERVICES.**

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:

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:** _____

Office use only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID #: _____ Effective date of coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ OEP: _____ Not eligible: _____

Agent use only: Agent name (please print): _____ **Agent NPN#:** _____