Sentara® Health Plans

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE PRESCRIPTION DRUG PLAN (PART D)

Who can use this form?

People who qualify to receive Medicare who want to join a Medicare Prescription Drug plan

To qualify for 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 Prescription Drug plan, you must also have either or both:

- Medicare Part A (hospital insurance)
- Medicare Part B (medical insurance)

When do I use this form?

You can use this form to join a plan:

- Between October 15 to December 7 each year (for coverage starting January 1)
- 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 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, if there is one. 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 after you complete this form?

Send your completed and signed form to:

Flexible Benefit Administrators, Inc.
P.O. Box 2070
Virginia Beach, VA 23450

Once we process your request to join, you will be contacted.

How do I get help with this form?

Call Sentara Medicare Rx at **1-866-946-1406 (TTY: 711)**.
October 1–March 31 | 7 days a week | 8 a.m.–8 p.m.
April 1–September 30 | Monday–Friday | 8 a.m.–8 p.m.

Or, call Medicare at 1-800-MEDICARE (**1-800-633-4227**).
TTY users can call **1-877-486-2048**.

En español: Llame a Medicare gratis al **1-800-633-4227** 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.

Sentara® Health Plans

Sentara Medicare Rx

Enrollment request form

Contact Sentara Medicare Rx at **1-866-946-1406 (TTY: 711)** if you need information in another format or language.
We are available October 1–March 31, 7 days a week, 8 a.m.–8 p.m. and April 1–September 30, Monday–Friday, 8 a.m.–8 p.m.

Section 1 – To enroll in Sentara Medicare, please provide the following required information:

Select the plan you want to enroll in.

☐ **Sentara Medicare Rx (PDP)**	**Effective Date Requested:**

☐ Mr. ☐ Mrs. ☐ Ms.	FIRST name:	Middle initial:	LAST name:
Birth date: (MM/DD/YYYY)	Sex: ☐ M ☐ F	Home phone number: ( ) Mobile phone number: ( )	

☐ By checking this box, you are consenting to Sentara Medicare and its representatives contacting you at any phone number you have provided to us, which may include mobile phone numbers. You understand that you are not required to agree, and agreeing is not a condition of being a Sentara Medicare member or receiving healthcare. Communications directed to these phone numbers may be carried out using automated dialing/delivery devices, direct dial, text message, SMS (short message service) or RCS (rich communication services) messages, ringless voicemail, and prerecorded or artificial voices. Communications may include, but may not be limited to, information regarding medication, wellness, preventive care, communication preferences, and payment. Communications and their content, which may include health information, will not be encrypted. You may revoke this consent at any time. To opt out of phone calls, call **1-877-552-7401** from October 1–March 31, 7 days a week, 8 a.m.–8 p.m. and April 1–September 30, Monday–Friday, 8 a.m.–8 p.m. To opt out of text messages, text STOP to short code 59270 or call **1-877-552-7401**. If you are not the subscriber to the phone number you provided, then you agree you have obtained the subscriber's consent to receive these communications. Sentara Medicare will not charge you for these communications. Carrier message and data rates may apply.

Email address:		
Permanent residence street address: **(P.O. Box is not allowed)**		Apt. #
City or county:	State: **VA**	ZIP code:
Mailing address - Street address/P.O. Box: (**only if different from your permanent residence address**):		Apt. #
City or county:	State:	ZIP code:

Your Medicare insurance information

Medicare number:

Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Sentara Medicare Rx (PDP)?
☐ Yes ☐ No

Name of other coverage:	Member number for this coverage:	Group number for this coverage:

IMPORTANT: Read and sign below

- I must keep Hospital (Part A) or Medical (Part B) to stay in Sentara Medicare Rx (PDP).
- By joining this Medicare Prescription Drug plan, I acknowledge that Sentara Medicare Rx (PDP) 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 Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand 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 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:	**Today's date:**
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, Puerto Rican
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ 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.**

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.

If you need languages other than English or if you want us to send information in an accessible format, please contact Sentara Medicare Rx (PDP) at **1-800-211-5417 (TTY: 711)**. We are available October 1–March 31, 7 days a week, 8 a.m.–8 p.m. and April 1–September 30, Monday–Friday, 8 a.m.–8 p.m.

List your primary care physician (PCP), clinic, or health center:

I want to get the following materials via email or mail. Select one.

- ☐ Sentara Medicare Rx (PDP) formulary via email
- ☐ Sentara Medicare Rx (PDP) formulary via mail

Email address:

- ☐ I give Sentara Medicare permission to send my plan materials and member communications, excluding EOBs, by email.

What is your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____
- ☐ **I choose not to answer**

How do you identify your sexual orientation? Select one.

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ I don't know
- ☐ **I choose not to answer**

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

Section 3 – Paying your plan premiums:

Part D-income related monthly adjustment amount (Part D-IRMAA) is a premium amount separate from the Part D plan's monthly premium for individuals who have incomes over a certain amount. The Social Security Administration assesses the amount annually based on the enrollee's available tax information. The plan does not collect the Part D-IRMAA as part of its premium. Typically, individuals pay the Part D-IRMAA through their Social Security, Office of Personnel Management, or Railroad Retirement Board (RRB) benefit withholding. Some enrollees are directly billed for their Part D-IRMAA through invoices sent by the Centers for Medicare & Medicaid Services (CMS) or the RRB. All Part D enrollees who are assessed the Part D-IRMAA are required to pay the IRMAA even if the Part D coverage is provided through an employer group health plan (EGHP).

Privacy Act Statement

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30, and 423.32 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.

Attestation of eligibility for an enrollment period

Typically, you may enroll in a Prescription Drug plan only during the annual enrollment period from October 15 through December 7 each year. There are exceptions that may allow you to enroll in a Prescription Drug plan outside of this period.

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, to the best of your knowledge, you are eligible for an enrollment period. If we later determine this information is incorrect, you may be disenrolled.

- ☐ I am enrolled in a Prescription Drug plan and want to make a change during the Medicare Advantage annual enrollment period (AEP).
- ☐ I am new to Medicare.
- ☐ I am enrolled in a Prescription Drug plan and want to make a change during the Medicare Advantage open enrollment period (OEP).
- ☐ 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 I 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). 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.

Attestation of eligibility for an enrollment period

☐ 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) _____.

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a federal, state, or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

☐ Other: _____

_____

If none of these statements applies to you or you're not sure, please contact Sentara Medicare Rx (PDP) at **1-800-211-5417 (TTY: 711)** to see if you are eligible to enroll. We are open October 1–March 31, 7 days a week, 8 a.m.–8 p.m. and April 1–September 30, Monday–Friday, 8 a.m.–8 p.m.

Sentara Medicare is a PDP plan with a Medicare contract. Enrollment in Sentara Medicare Rx (PDP) depends on contract renewal.