Prominence®
Health Plan

ENROLLMENT FORM

Prominence Health Plan (HMO)
Texas Individual Enrollment Request Form
Medicare Advantage with Prescription Drug Coverage
ENROLLMENT INSTRUCTIONS

The following steps must be completed to become a member of Prominence Health Plan. Prominence Health Plan is an HMO plan with a Medicare contract. Enrollment in Prominence Health Plan depends on contract renewal.

1. Please fill out the entire form legibly and accurately. Your Medicare information must be filled out exactly as it appears on your Medicare card.
2. Choose your plan. Each area has one plan option: The Plus plan with the option to purchase an optional supplemental package for comprehensive dental. Make sure you select the plan that you want in the area where you live.
3. Be sure to read each item carefully so that you fully understand the information.
4. You must sign and date the enrollment form.

For Enrollment Assistance or Questions
Please call: 1-833-388-4747
TTY: 711

Dates	Days	Times
October 1 to March 31	7 days a week	8 a.m. to 8 p.m.
April 1 to September 30	Monday through Friday	8 a.m. to 8 p.m.

ProminenceMedicare.com

Please note that Prominence Health Plan cannot consider this application "complete" until your eligibility for Medicare Part A and enrollment in Medicare Part B has been confirmed.

Prominence Health Plan • 1510 Meadow Wood Lane • Reno, NV 89502-9905 • Fax: 775-770-9144

Y0109_TXEF19a_M CMS Accepted

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

To Enroll in Prominence Health Plan, Please Provide the Following Information

Please check which plan you want to enroll in:

❑ **Prominence Plus HMO H7680, Plan 001: $0 per month**
Texas Counties: Cooke, Deaf Smith, Fannin, Gray, Grayson, Moore, Potter and Randall

Optional Supplemental Benefit (Dental) **Texas Counties:** Cooke, Deaf Smith, Fannin, Gray, Grayson, Moore, Potter and Randall
❑ Add $23.00 per month to include comprehensive dental coverage up to $1,000 with a $50 deductible

❑ **Prominence Plus HMO H7680, Plan 002: $0 per month**
Texas Counties: Brooks, Hidalgo and Starr

Optional Supplemental Benefit (Dental)
Texas Counties: Brooks, Hidalgo and Starr
❑ Add $22.00 per month to include comprehensive dental coverage up to $1,000 with a $50 deductible

LAST Name: (use boxes below) ❑ Mr. ❑ Mrs. ❑ Ms.

FIRST Name: (use boxes below) MI:

Birth Date: M M D D Y Y Y Y Sex: ❑ M ❑ F

Home Phone Number:

Alternate Phone Number: (optional)

Permanent Residence Street Address 1:
(PO Box is not allowed)

Street Number Street Name Lot/Apartment

City: State: Zip Code:

County:

Mailing Address (only if different from your Permanent Residence Address):

Street Number Street Name Lot/Apartment

City: State: Zip Code:

Emergency contact: (optional)

FIRST Name: MI LAST Name:

Phone Number: Relationship to you:

E-mail Address: (optional)

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name: (as it appears on your Medicare card)

Medicare Number:

Effective Date:

Is Entitled to M M D D Y Y Y Y

HOSPITAL (Part A)

MEDICAL (Part B)

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Paying 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 your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. You can also choose to 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 Prominence Health Plan the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible 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 www.socialsecurity.gov/prescriptionhelp.

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

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

Please select a premium payment option:

❑ Get a bill.

❑ Automatic deduction from your monthly: Social Security or Railroad Retirement Board (RRB) benefit check.
I get monthly benefits from: ❑ Social Security ❑ RRB

(The Social Security/RRB 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 answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? ❑ YES ❑ NO

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Prominence Health Plan? ❑ YES ❑ NO

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:

ID # for this coverage:

Group # for this coverage:

3. Are you a resident in a long-term care facility, such as a nursing home? ❑ YES ❑ NO

If "yes" please provide the following information:

Name of Institution:

Phone Number:

Address: (Number and Street)

4. Are you enrolled in your State Medicaid program? ❑ YES ❑ NO

If yes, please provide your Medicaid number:

5. Do you or your spouse work? ❑ YES ❑ NO

Please choose the NAME of a Primary Care Physician (PCP), clinic or health center:

FIRST Name: (use boxes below) MI: LAST Name:

Are you an existing member of this PCP? ❑ YES ❑ NO

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 ❑ Vietnamese ❑ Large Print

Please contact Prominence Health Plan at 1-855-969-5882 if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. to 8 p.m. seven days a week, from October 1 - March 31 and Monday through Friday from April 1 - September 30. TTY users should call 711.

Please Read This Important Information STOP

If you currently have health coverage from an employer or union, joining Prominence Health Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Prominence Health Plan. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

Prominence Health Plan is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

Prominence Health Plan serves a specific service area. If I move out of the area that Prominence Health Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Prominence Health Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Prominence Health Plan when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Prominence Health Plan coverage begins, I must get all of my health care from Prominence Health Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Prominence Health Plan and other services contained in my Prominence Health Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR PROMINENCE HEALTH PLAN WILL PAY FOR THE SERVICES.**

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

Release of Information: By joining this Medicare health plan, I acknowledge that Prominence Health Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Prominence Health Plan 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 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: M M D D Y Y Y Y

If you are the authorized representative, you must sign above and provide the following information:

Name: **Phone Number:**

Address:

Relationship to Enrollee:

OFFICE USE ONLY:

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

First | Last | Agent ID#:

Signature: _____

Plan ID#:

Effective Date of Coverage: (M M /D D/ Y Y Y Y)

Election Type: ❑ ICEP/IEP ❑ AEP ❑ SEP (TYPE) ❑ Not Eligible

Current Insurance: _____

TR K-1 ❑ Referral by Provider ❑ Referral by Member ❑ Company Website ❑ Media (TV, News Ad, Mag)
❑ Direct Mail ❑ Local Community Event ❑ Word of Mouth

Online/Telephonic Application Confirmation #

Date Received:

Prominence®
Health Plan

Information to include with Enrollment Mechanism

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage 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 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 am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA 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 (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ I recently was released from incarceration. I was released on (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ I recently obtained lawful presence status in the United States. I got this status on (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid on (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ 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 (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ 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 or long-term care facility). I moved/will move into/out of the facility on (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ I recently left a PACE program on (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ I am leaving employer or union coverage on (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ 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 (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ 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 (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ 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.

If none of these statements applies to you or you're not sure, please contact Prominence Health Plan at 1-855-969-5882 (TTY users should call 711) to see if you are eligible to enroll. We are open 8 am to 8 pm, seven days a week from October 1 - March 31 and Monday through Friday from April 1 – September 30.

OFFICE USE ONLY:

Enrollee's LAST Name: (use boxes below) FIRST Name: MI:

Medicare Claim # ☐☐☐ ☐☐ ☐☐☐☐☐☐☐

Effective Date: M M D D Y Y Y Y ☐☐ ☐☐ ☐☐☐☐