2024 Individual Enrollment Request Form

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 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 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: **SCAN Health Plan**
Attention: Enrollment and Reconciliation
PO BOX 22616
LONG BEACH CA 90801

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

How do I get help with this form?

Call SCAN Health Plan at **1-855-827-7226**, TTY users can call (TTY: 711).
Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a SCAN Health Plan al 1-855-827-7226 TTY:711 o 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.

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

Select the plan you want to join:

SCAN Classic (HMO)

- ☐ 001 Clark County $0 per month
- ☐ 005 Nye County $0 per month

SCAN Compass (HMO)

- ☐ 009 Clark and Nye Counties $0 per month

SCAN MyChoice (HMO)

- ☐ 011 Clark County $0 per month

SCAN Venture (HMO)

- ☐ 004 Clark County $0 per month
- ☐ 008 Nye County $0 per month

SCAN Balance (HMO C-SNP)

- ☐ 002 Clark County $0 per month
- ☐ 006 Nye County $0 per month

SCAN Heart First (HMO C-SNP)

- ☐ 003 Clark County $0 per month
- ☐ 007 Nye County $0 per month

SCAN Strive (HMO C-SNP)

- ☐ 010 Clark County $32.00 per month

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. See "What happens next?" on this page to send your completed form to the plan.

1 All fields on this page are required (unless marked optional) *(continued)*

Last Name:

First Name: **M.I.**

Birth Date: M M / D D / Y Y Y Y **Sex:** ☐ Male ☐ Female

Phone Number: ( ) -

Permanent Residence Street Address (Don't enter a P.O. Box):

City: State: ZIP Code:

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

Street Address:

City: State: ZIP Code:

Your Medicare information:

Medicare Number: - -

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to SCAN Health Plan? ☐ Yes ☐ No

Name of other coverage: _____

Member number for this coverage: _____Group number for this coverage _____

Are you enrolled in your state Medicaid program? ☐ Yes ☐ No

If "yes," please provide your Medicaid number: _____

Complete only if you are enrolling in a SCAN Heart First (HMO C-SNP) or SCAN Strive (HMO C-SNP) plan.

Has your doctor diagnosed you with one of the following conditions?

Congestive heart failure	☐ Yes	☐ No
Coronary artery disease	☐ Yes	☐ No
Cardiac arrhythmia	☐ Yes	☐ No
Peripheral vascular disease	☐ Yes	☐ No
Chronic venous thromboembolic disorder	☐ Yes	☐ No

Complete only if you are enrolling in a SCAN Balance (HMO C-SNP) or SCAN Strive (HMO C-SNP) plan.

Has your doctor diagnosed you with diabetes? ☐ Yes ☐ No

1 All fields on this page are required (unless marked optional) *(continued)*

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in SCAN Health Plan.
- By joining this Medicare Advantage Plan, I acknowledge that SCAN Health Plan 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 MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans)
- I understand that when my SCAN Health Plan coverage begins, I must get all of my medical and prescription drug benefits from SCAN Health Plan. Benefits and services provided by SCAN Health Plan and contained in my SCAN Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor SCAN Health Plan will pay for benefits or services that are not covered.
- 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 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: _____ **Today's Date:** ☐☐ - ☐☐ - ☐☐☐☐

If you're the authorized representative, sign above and fill out these fields:

Name:	Address:
Phone number:	Relationship to enrollee:

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.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ **I choose not to answer.**

What's your race? Select all that apply.

☐ American Indian or Alaska Native
☐ Chinese
☐ Japanese
☐ Other Asian
☐ Vietnamese
☐ **I choose not to answer.**
☐ Asian Indian
☐ Cambodian
☐ Filipino
☐ Korean
☐ Other Pacific Islander
☐ White
☐ Black or African American
☐ Guamanian or Chamorro
☐ Native Hawaiian
☐ Samoan
☐ Mixed Race
☐ Unknown

Email Opt-In: Email Address: _____

I want to get the following materials via email:

☐ By providing my email address, I agree to receive my SCAN materials online rather than by U.S. Mail. I understand this would include documents such as the Part C and Part D Explanation of Benefits (EOB), Annual Notice of Change (ANOC) and I can change back to U.S. mail at any time.

2 All fields on this page are optional *(continued)*

Texting Opt-in:	Mobile phone number: ( ) -
* By providing my number, I agree to receive automated and/or other text messages by SCAN Health Plan for healthcare, benefits, or any other purpose. Such consent is not a condition of receipt of any service and I can opt out at any time. Message and data rates may apply.	
Language Preferences:	Select one if you want us to send you information in a language other than English: ☐ Spanish ☐ Other
	What is your preferred spoken language if other than English: ☐ Spanish ☐ Other
Select one if you want us to send you information in an accessible format: ☐ Braille ☐ Large print ☐ Audio CD Please contact SCAN Health Plan at 1-855-827-7226 (TTY: 711) if you need information in an accessible format other than what's listed above. Our office hours are 8 A.M. to 8 P.M., seven days a week from October 1 to March 31. From April 1 to September 30 hours are 8 A.M. to 8 P.M., Monday through Friday. TTY users can call TTY 711.	
Do you work? ☐ Yes ☐ No	Does your spouse/partner work? ☐ Yes ☐ No
I do not have a preferred primary care physician. Please auto assign me to a contracted SCAN primary care physician. ☐ Yes ☐ No	
List your Primary Care Physician (PCP), clinic, or health center: _____	
Primary Care Physician Number: -	Medical Group Number:
Are you a current patient of this physician? ☐ Yes ☐ No	

3 Paying your Plan Premium

You can pay your monthly plan premium including any late enrollment penalty that you currently have or may owe 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. DON'T pay SCAN Health Plan the Part D-IRMAA.

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. You can set up your payment method of choice including Electronic Funds Transfer (EFT) or by Credit or Debit Card by calling SCAN Member Services at 1-855-827-7226 October 1 to March 31: 8 A.M. to 8 P.M., 7 days a week and April 1 to September 30: 8 A.M. to 8 P.M. Monday through Friday. TTY users.

You can also make payments online by going to www.scanhealthplan.com/members/register and registering your SCAN member account online.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) improve care, and for the payment of Medicare benefits. Sections 1851 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.

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.[1]
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).[2]
- ☐ 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:[3] ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I recently was released from incarceration. I was released on:[4] ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on:[5] ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I recently obtained lawful presence status in the United States. I got this status on:[6] ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on:[7] ☐☐ / ☐☐ / ☐☐☐☐
- ☐ 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:[8] ☐☐ / ☐☐ / ☐☐☐☐
- ☐ 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.[9]
- ☐ 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:[10] ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I recently left a PACE program on:[11] ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on:[12] ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I am leaving employer or union coverage on:[13] ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I belong to a pharmacy assistance program provided by my state.[14]
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.[15]
- ☐ 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:[16] ☐☐ / ☐☐ / ☐☐☐☐
- ☐ 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:[17] ☐☐ / ☐☐ / ☐☐☐☐
- ☐ 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.[18]
- ☐ I am in a Medicare Advantage plan that was recently taken over by the state or territorial regulatory authority because of financial issues.[19]
- ☐ I am in a Medicare Advantage plan that had a star rating of less than 3 stars for the last 3 years.[20]

If none of these statements applies to you or you're not sure, please contact SCAN Health Plan at 1-855-827-7226 (TTY: 711).

INTERNAL OFFICE USE ONLY		
NAME OF STAFF MEMBER/AGENT/BROKER (if assisted in enrollment):		NATIONAL PRODUCER NUMBER (NPN):
EFFECTIVE DATE OF COVERAGE: ☐☐ / ☐☐ / ☐☐☐☐		REC'D DATE: ☐☐ / ☐☐ / ☐☐☐☐
☐ EE DUP CONF#		
Emergency Contact (optional):	Phone Number:	Relationship to you: