2021 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 **1-800-559-3500**, 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 1-800-559-3500 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.

Y0057_SCAN_12110_2020_M 08192020 R1563 12/20 21F-ENRFORM

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

Select the plan you want to join:

SCAN Classic (HMO)
- ☐ 001 Ventura County $19 per month
- ☐ 006 Los Angeles County $0 per month
- ☐ 007 Orange County $0 per month
- ☐ 008 Riverside County $0 per month
- ☐ 009 San Bernardino County $0 per month
- ☐ 019 San Francisco County $35 per month
- ☐ 020 Santa Clara County $54 per month
- ☐ 052 Napa and Sonoma Counties $34 per month
- ☐ 069 Stanislaus County $0 per month

SCAN Compass (HMO)
- ☐ 074 Napa and Sonoma Counties $25 per month

SCAN Balance (HMO SNP)
- ☐ 034 Los Angeles and Orange Counties $0 per month
- ☐ 054 Napa and Sonoma Counties $38 per month
- ☐ 070 Stanislaus County $0 per month

SCAN Heart First (HMO SNP)
- ☐ 028 Orange County $0 per month
- ☐ 033 Riverside and San Bernardino Counties $0 per month
- ☐ 053 Napa and Sonoma Counties $38 per month

SCAN Classic II (HMO)
- ☐ 064 Los Angeles County $59 per month

SCAN Options (HMO)
- ☐ 073 Santa Clara County $0 per month

SCAN Prime (HMO)
- ☐ 065 Los Angeles County $25 per month
- ☐ 066 Orange County $26 per month
- ☐ 067 Riverside County $23 per month
- ☐ 068 San Bernardino County $23 per month

Scripps Classic offered by SCAN Health Plan (HMO)
- ☐ 005 San Diego County $0 per month

Scripps Signature offered by SCAN Health Plan (HMO)
- ☐ 004 San Diego County $74 per month

Scripps Heart First offered by SCAN Health Plan (HMO SNP)
- ☐ 055 San Diego County $26 per month

Scripps Plus offered by SCAN Health Plan (HMO)
- ☐ 040 San Diego County $31.50 per month

SCAN Plus (HMO)
- ☐ 045 Los Angeles, Orange, Riverside, San Bernardino, San Francisco and Ventura Counties $31.50 per month
- ☐ 071 Stanislaus County $31.50 per month
- ☐ 072 Santa Clara County $31.50 per month

SCAN Healthy at Home (HMO SNP)
- ☐ 006 Los Angeles, Orange, Riverside and San Bernardino Counties $0 per month

SCAN Connections (HMO SNP)
- ☐ 010 Los Angeles, Riverside and San Bernardino Counties $0 per month

SCAN Connections at Home (HMO SNP)
- ☐ 030 Los Angeles, Riverside and San Bernardino Counties $0 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.

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

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 Medi-Cal (Medicaid) program? ☐ Yes ☐ No

If "yes," please provide your Medi-Cal (Medicaid) number: _____

Complete only if you are enrolling in a SCAN Heart First (HMO 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 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.
- 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 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.
- 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.

Select one if you want us to send you information in a language other than English. ☐ Spanish ☐ Chinese	
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 1-800-559-3500 (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 work? ☐ Yes ☐ No
List your Primary Care Physician (PCP), clinic, or health center:	Are you a current patient of this physician? ☐ Yes ☐ No
I want to get the following materials via email. ☐ Check here to get your Part C Explanation of Benefits (EOB) and Annual Notice of Change (ANOC) online, rather than by U.S. mail. You will receive an e-mail each time one of these documents is available. You can change back to U.S. mail at any time. E-mail address:_____	

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. 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 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.**

☐ **Electronic Funds Transfer (EFT) from your bank account each month.** Please enclose a VOIDED check or provide the following:

Account Holder Name:

Bank Routing Number:

Bank Account Number:

Account Type: ☐ Checking ☐ Saving

☐ **Credit Card/Debit Card.** Please provide the following information: Type of card: ☐ VISA ☐ M/C ☐ AMEX ☐ Discover

Name of Account holder as it appears on card:

Account Number:

Expiration Date: / (MM/YYYY) Security Code:

☐ **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.

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

Annual enrollment period is from October 15 through December 7. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period. 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: ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I recently was released from incarceration. I was released on: ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I recently returned to the United States after living permanently outside of the U.S.
  I returned to the U.S. on: ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I recently obtained lawful presence status in the United States. I got this status on: ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on:
  ☐☐ / ☐☐ / ☐☐☐☐
- ☐ 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: ☐☐ / ☐☐ / ☐☐☐☐
- ☐ 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: ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I recently left a PACE program on: ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
  I lost my drug coverage on: ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I am leaving employer or union coverage on: ☐☐ / ☐☐ / ☐☐☐☐
- ☐ 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:
  ☐☐ / ☐☐ / ☐☐☐☐
- ☐ 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: ☐☐ / ☐☐ / ☐☐☐☐
- ☐ 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.
- ☐ I am in a Medicare Advantage plan that was recently taken over by the state or territorial regulatory authority because of financial issues.
- ☐ I am in a Medicare Advantage plan thats had a star rating of less than 3 stars for the last 3 years.

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: ☐☐ / ☐☐ / ☐☐☐☐
Enrollee's preferred spoken language (if other than English):		☐ EE DUP CONF#
Emergency Contact (optional):	Phone Number:	Relationship to you: