New York

Medicare Advantage Enrollment Form

In Collaboration with

bright HEALTH | Mount Sinai

Please contact Bright Health at (844) 679-2030 if you need information in another language or format (e.g. braille, large print, audio tape).

To Enroll in Bright Health Please Provide the Following Information:

Please check which plan you want to enroll in:

Contract	PBP	Plan Name	Plan Type	Premium
☐ H2288	001	Bright Advantage	HMO	$0
☐ H2288	002	Bright Advantage Plus	HMO	$55
☐ H2288	005	Bright Advantage Assist	HMO	As low as $0*
☐ H2288	008	Bright Advantage Choice	HMO	$0
☐ H9516	001	Bright Advantage Flex	PPO	$0
☐ H9516	002	Bright Advantage Flex Plus	PPO	$95

Please check which Optional Supplemental Benefits (OSB) Plan you want to enroll in:

Dental

Contract	PBP	Plan Name	Plan Type	Premium
☐ H2288	001	Bright Advantage	Comprehensive Dental	$13
☐ H2288	008	Bright Advantage Choice	Comprehensive Dental	$13
☐ H9516	001	Bright Advantage Flex	Comprehensive Dental	$18

Vision

Contract	PBP	Plan Name	Plan Type	Premium
☐ H2288	008	Bright Advantage Choice	Vision	$4

Disclaimer: *If you lose full Extra Help, you may be responsible for the full monthly premium amount for your plan.

☐ Mr. ☐ Mrs. ☐ Ms.			
LAST Name:	FIRST Name:		MI:
Birthdate (MM/DD/YYYY): __ __ / __ __ / __ __ __ __	Sex: ☐ M ☐ F		
Home Phone Number: (__ __ __) __ __ __ - __ __ __ __	Alternate Phone Number: (__ __ __) __ __ __ - __ __ __ __		
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	County:	State:	ZIP Code:
Mailing Address (only if different form your Permanent Residence Address):			
City:	County:	State:	ZIP Code:
Emergency Contact:			
Emergency Contact Phone Number: (__ __ __) __ __ __ - __ __ __ __	Relationship to You:		
Email Address:			

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 form Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card):	
	Medicare Number:	
	Is Entitled to:	Effective Date:
	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 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 (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 Bright Health the Part D-IRMAA.

You can pay your monthly plan premium (including any late enrollment penalty that you currently 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 (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 RRB. DO NOT pay Bright Health 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 co-insurance. 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:

☐ Monthly Invoice

☐ 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

☐ 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 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 yes, and 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. Do you have additional coverage (e.g., TRICARE, Federal employee health benefits coverage, VA benefits , or State pharmaceutical assistance programs etc.)? ☐ Yes ☐ No

If yes, please tell us what it covers along with information on the other coverage:
☐ Medical ☐ Prescription Drugs

Name of Other Insurance: _____
Member ID Number: _____ Group ID Number: _____

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: _____
Address & Phone Number of Institution (number and street): _____

4. Are you enrolled in your State Medicaid Program? ☐ Yes ☐ No

If yes, please provide your state Medicaid number

_____

5. Do you or your spouse work? ☐ Yes ☐ No

Primary Care Physician (PCP)

Please tell us the name of your Primary Care Provider (PCP):

First Name	Last Name

Are you already a patient of the provider you listed above? ☐ 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 ☐ Chinese ☐ Other_____

☐ Braille ☐ Audio Tape ☐ Large Print

Please contact Bright Health at (844) 679-2030 if you need information in an accessible format or language other than what is listed above. Our office hours are 8am to 8pm local time, 7 days a week, Oct 1. – Mar. 31, Monday – Friday, Apr. 1 – Sept. 30, TTY users should call (TTY: 711).

STOP! Please Read this Important Information

If you currently have health coverage from an employer or union, joining Bright Health could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Bright Health. 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:

Bright Health 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.

Bright Health serves a specific service area. If I move out of the area that Bright Health 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 Bright Health, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Bright Health 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.

Services authorized by Bright Health and other services contained in my Bright Health Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BRIGHT HEALTH WILL PAY FOR THE SERVICES**.

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

If you are requesting enrollment in an HMO plan the following statement applies: I understand that beginning on the date Bright Health coverage begins, I must get all of my health care from Bright Health participating providers, except for emergency or urgently needed services or out-of-area dialysis services.

If you are requesting enrollment in an PPO plan the following statement applies: I understand that beginning on the date Bright Health coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Bright Health provides reimbursement for all covered benefits, even if I get services out of network.

Release of Information: By joining this Medicare health plan, I acknowledge that Bright Health will release my information to Medicare and other plans as necessary other parties for treatment, payment and health care operations, including without limitation to Medicare, other plans, providers, and Bright Health's Care Partner. I also acknowledge that Bright Health 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 form 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:**

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 the enrollment):	
Broker/Agent #:	
Plan ID#:	Effective Date of Coverage:
ICEP/IEP: _____ AEP: _____ SEP Type: _____ Not Eligible: _____	

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 this period.

Read the following statements carefully and check the box if a 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 (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 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 (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.
- ☐ 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 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 Bright Health at (844) 679-2030 (TTY users should call (TTY: 711) to see if you are eligible to enroll. We are open 8am – 8pm local time, 7 days a week (Oct. 1 – Mar. 31) or Monday-Friday (Apr. 1 – Sept. 30).