OMB No. 0938-1378
Expires: 7/31/2025

TheHealthPlan

INDIVIDUAL ENROLLMENT REQUEST FORM- MEDICARE ADVANTAGE

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 didn'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:

The Health Plan
1110 Main Street
Wheeling, WV
26003-2704

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

How do I get help with this form?
Call The Health Plan at 1.877.847.7915. TTY users can call: 711.

Or, call Medicare at 1.800.MEDICARE (1.800.633.4227). TTY users can call 1.877.486.2048.

En español: Llame a The Health Plan al 1.877.847.7915 /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, and 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.

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.

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

Select the plan you want to join:

☐ SecureCare Integrity Plan 2 HMO. Plan number H3672-024. Plan Premium is $0 per month.
☐ YES, I would like to enroll in the Optional Supplemental Dental Plan, with an additional premium of $35.50 per month.

☐ SecureCare Capitol Plan HMO. Plan number H3672-023. Plan Premium is $0 per month.
☐ YES, I would like to enroll in the Optional Supplemental Dental Plan, with an additional premium of $35.50 per month.

☐ SecureChoice Option II PPO. Plan number H8604-011. Plan Premium is $109.00 per month.
☐ YES, I would like to enroll in the Optional Supplemental Dental Plan, with an additional premium of $35.40 per month.

☐ SecureChoice Optimum PPO. Plan number H8604-014-2. Plan Premium is $0 per month.
☐ YES, I would like to enroll in the Optional Supplemental Dental Plan, with an additional premium of $35.40 per month.

FIRST Name:	LAST Name:	(Optional) Middle Initial:
Birth Date: (MM/DD/YYYY) ____/____/_____	Sex: ☐ Male ☐ Female	Phone Number: ( )
Permanent Residence Street Address: (Don't enter a P.O. Box)		
City:	(Optional) County:	State: ZIP Code:
Mailing Address, if different from your permanent address: (P.O. 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 The Health Plan? ☐ Yes ☐ No

Name of other coverage: _____

Member number for this coverage: _____ Group number for this coverage:_____

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IMPORTANT: Read and sign below:	
• I must keep both Hospital (Part A) and Medical (Part B) to stay in The Health Plan. • By joining this Medicare Advantage Plan, I acknowledge that The 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 The Health Plan coverage begins, I must get all of my medical and prescription drug benefits from The Health Plan. Benefits and services provided by The Health Plan and contained in my The Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor The 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. • By providing my contact information, including my phone number and email address, I grant consent to The Health Plan to contact me using this information regarding my benefits and/or to manage my care, including notifying me about benefits to which I may be entitled.	
Signature:	**Today's Date:**
If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone Number:	Relationship to Enrollee:

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Section 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
- ☐ 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**

Select one if you want us to send you information in a language other than English.

- ☐ Please contact The Health Plan for materials that are available in other languages.

Select one if you want us to send you information in an accessible format.

- ☐ Braille ☐ Large Print ☐ Audio CD

Please contact The Health Plan at 1.877.847.7915 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 through March 31 and 8 a.m. to 8 p.m., Monday through Friday from April 1 through September 30. TTY users can call 711.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic or health center:

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

- ☐ Please contact The Health Plan for materials that are available to be sent by email.

E-mail address: _____

Paying your plan premiums

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 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 The Health Plan the Part D-IRMAA.

Plan premium payment option (Please note: If you don't select a payment option, you will be billed directly by The Health Plan.)

Select a premium payment option:

- ☐ By Mail- Get payment coupons.
- ☐ Electronic Funds Transfer (EFT) from your bank account each month.
  * Additional forms may be needed to complete this authorization. Please contact the plan for details.
- ☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

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 The Health Plan the Part D-IRMAA.

PRIVACY ACT STATEMENT The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, 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.

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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 (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 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) 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.

If none of these statements applies to you or you're not sure, please contact The Health Plan at 1.877.847.7915 (TTY users should call 711) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., seven days a week from October 1 through March 31 and 8 a.m. to 8 p.m., Monday through Friday from April 1 through September 30.

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AGENT USE ONLY
Appointment Type: _____ Scope of Appointment ID Number: _____
Print Agent name: _____
Agent Writing Number (AWN): _____ Agent Phone Number: _____

NOTE: If Agent takes receipt of this application, signature and date are required below:
Signature of Agent: _____
Date Individual Enrollment Request Form received By Agent: _____
Agent: Please be sure to copy and maintain this and all pages of the completed application for your records.

OFFICE USE ONLY:
Name of staff member/agent/broker (if assisted in enrollment): _____ Sales Method Code _____
Agent ID: ____ Plan ID #: _____ Group #: _____
Member/Client ID: _____ Effective Date of Coverage: _____
Date Received: _____ Check Number: _____ Check Amount: _____
ICEP/IEP: _____ AEP: _____ OEP: _____ SEP (type): _____
Not Eligible: _____

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Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1.877.847.7915 (TTY: 711)**.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit healthplan.org/medicare or call **1.877.847.7915 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ Effect on Current Coverage. Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.
- ☐ In addition to your monthly plan premium (if applicable), you must continue to pay your Medicare Part B premium if not otherwise paid by a third party like the state. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2026.
- ☐ (**HMO plans**) Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ (**PPO plans**) Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

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Discrimination is Against the Law

The Health Plan of West Virginia (The Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, creed, ancestry, religion, national origin, age, disability, marital status, health status, income level, or sex (consistent with the scope of sex discrimination as described by applicable law).
The Health Plan does not exclude people or treat them less favorably because of race, color, creed, ancestry, religion, national origin, age, disability, marital status, health status, income level, or sex.

The Health Plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Director, Health Equity & Wellness.

If you believe that The Health Plan of West Virginia has failed to provide these services or discriminated in another way on the basis of race, color, creed, ancestry, religion, national origin, age, disability, marital status, health status, income level, or sex, you can file a grievance with: Director, Health Equity & Wellness, 1110 Main Street, Wheeling, West Virginia 26003, Phone: 740.699.6142, TTY: 711, Fax: 740.699.6163, civilrightscoordinator@healthplan.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Director, Health Equity & Wellness is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 1.800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at The Health Plan's website: healthplan.org.

TheHealthPlan
1110 Main Street, Wheeling, WV 26003-2704 | healthplan.org

English

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1.877.847.7907 (TTY: 711) or speak to your provider.

Spanish

Español
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1.877.847.7907 (TTY: 711) o hable con su proveedor.

Chinese (Simplified)

中文 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提 供适当的辅助工具和服务，以无障碍格式提供信息。致电 1.877.847.7907 (TTY: 711) 或咨询您的服务提供商。

Chinese (Traditional)

中文
注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1.877.847.7907 (TTY: 711) 或與您的提供者討論。

German

Deutsch
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1.877.847.7907 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Arabic

العربية
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1.877.847.7907 (TTY: 711) أو تحدث إلى مقدم الخدمة.

Pennsylvania Dutch
Hinweis: Wenn du Pennsylvaniä Deitsch redst, kannscht du kostenlose Sprachhilfe-Dienste nutze. Auwersichtliche Hilfsmittel und Dienste, um Information in zugängliche Formate zu gebbe, sin au kostenlos verfügbar. Ruf 1.877.847.7907 (TTY: 711) an oder red mit deinem Anbieter für Hilfe.

Russian
РУССКИЙ
ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1.877.847.7907 (TTY: 711) или обратитесь к своему поставщику услуг.

French
Français
ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1.877.847.7907 (TTY: 711) ou parlez à votre fournisseur.

Vietnamese
Việt
LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1.877.847.7907 (TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Korean
한국어
주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1.877.847.7907 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Cushite (Oromo)
HUBACHIISA: Afaan Oromoo dubbattu yoo ta'eef, tajaajilli gargaarsa Afaan Hiikuu (Turjumaanaa) bilisaan kan isiniif dhiyaatu ta'a. Gargaarsi walqabataa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa unkaalee dhaqqabamoo ta'aniin kennuunis bilisaan ni argama. 1.877.847.7907 (TTY: 711) irratti bilbilaa ykn dhiyeessaa keessan waliin haasa'aa.

Japanese
日本語
注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1.877.847.7907 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

Italian
Italiano
ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama 1.877.847.7907 (TTY: 711) o parla con il tuo fornitore.

Dutch
Nederlands
LET OP: als je Nederlands spreekt, zijn er gratis taalhulpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel 1.877.847.7907 (TTY: 711) of spreek met je provider.

Ukrainian
українська мова
УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1.877.847.7907 (TTY: 711) або зверніться до свого постачальника.

Romanian
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. De asemenea, sunt disponibile gratuit ajutoare și servicii auxiliare adecvate pentru a furniza informații în formate accesibile. Sunați la 1.877.847.7907 (TTY: 711) sau vorbiți cu furnizorul dvs.

Tagalog
PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1.877.847.7907 (TTY: 711) o makipag-usap sa iyong provider.

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TheHealthPlan