FRH21APP5427

Enrollment form

Freedom Health, Inc.
MA-MAPD 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 monthly Social Security or Railroad Retirement Board benefits.

What happens next?

Send your completed and signed form to:

Freedom Health, Inc.
P.O. Box 151108
Tampa, FL 33684

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

How do I get help with this form?

Call Freedom Health at 1-800-401-2740. 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 Freedom Health al 1-800-401-2740/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.

FREEDOM HEALTH

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

Select the plan you want to join:

- ❑ Freedom Platinum Plan Rx (HMO): **$0** per month
- ❑ Freedom Medicare Plan Rx (HMO): **$0** per month
- ❑ Freedom Medi-Medi Partial (HMO D-SNP): **$30.80** per month
- ❑ Freedom Medi-Medi Full (HMO D-SNP)*: **$30.80** per month

*(For QMB and QMB full-benefit dual eligible only)

- ❑ Freedom Platinum Rewards Plan Rx (HMO): **$0** per month
- ❑ Freedom VIP Savings (HMO C-SNP): **$0** per month
- ❑ Freedom VIP Care (HMO C-SNP): **$0** per month
- ❑ Freedom VIP Rewards (HMO C-SNP): **$0** per month
- ❑ Freedom VIP Savings COPD (HMO C-SNP): **$0** per month
- ❑ Freedom Savings Plan (HMO)**: **$0** per month

**(MA Only Plan, No Drug Coverage)

LAST name: FIRST name: (Optional) MI:

Birth date: M M D D Y Y Y Y

Sex: ❑ Male ❑ Female

Phone number:

Permanent Residence Street Address 1: (Don't enter a PO Box)

Street Number Street Name Lot/Apartment

City: State: Zip Code:

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

Street Number Street Name Lot/Apartment

City: State: Zip Code:

E-mail address (optional):

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

❑ Evidence of Coverage ❑ Formulary (List of Covered Drugs) ❑ Provider & Pharmacy Directory ❑ Summary of Benefits

Your Medicare information:

Medicare Number: - -

Answer these important questions:

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

Name of other coverage: Member number for this coverage: Group number for this coverage:

Please choose the NAME of a Primary Care Physician (PCP), Clinic or Health Center: **PCP ID Number:**

FIRST name: MI: LAST name:

Are you an existing member of this PCP? ❑ Yes ❑ No

Dual Special Needs Plans Criteria: If you are applying for any one of the following plans, then please provide your Medicaid ID.

Medicaid ID#

- Freedom Medi-Medi Partial (HMO D-SNP)
- Freedom Medi-Medi Full (HMO D-SNP)

Chronic Special Needs Plans Criteria: If you are applying for any one of the following plans, then please fill out 'Chronic Special Needs Plan (SNP) Pre-Qualification Form' attached at the end of this Application Form.

- Freedom VIP Care (HMO C-SNP)
- Freedom VIP Savings (HMO C-SNP)
- Freedom VIP Savings COPD (HMO C-SNP)
- Freedom VIP Rewards (HMO C-SNP)

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Freedom Health.
- By joining this Medicare Advantage Plan, I acknowledge that Freedom Health 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 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 Freedom Health coverage begins, I must get all of my medical and prescription drug benefits from Freedom Health. Benefits and services provided by Freedom Health and contained in my Freedom Health "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Freedom Health 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: M M D D Y Y Y Y

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

LAST name:

FIRST name:

(Optional) MI:

Permanent Residence Street Address:

Street Number

Street Name

Lot/Apartment

City:

State:

Zip Code:

Phone Number:

Relationship to Enrollee:

Section 2 - All fields below 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

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

❑ Large print ❑ Braille ❑ Audio CD

Please contact Freedom Health at 1-800-401-2740 if you need information in an accessible format other than what's listed above. Our office hours are from October 1st to March 31st from 8 a.m. to 8 p.m. EST 7 days a week and from April 1st to September 30th from 8 a.m. to 8 p.m. EST Monday through Friday. TTY users can call 711.

Do you work? ❑ Yes ❑ No

Does your spouse work? ❑ Yes ❑ No

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 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 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 benefit check, or
❑ Railroad Retirement Board (RRB) benefit check

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 Freedom Health the Part D-IRMAA.

OFFICE USE ONLY:

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

Effective Date: (MM/DD/YYYY)

Agent Signature: _____ Agent Received Date:

Election Type: ❑ ICEP/IEP ❑ AEP ❑ MA OEP ❑ SEP(type) ❑ Not Eligible

Agency of Agent:_____ Current Insurance:_____

Agent Name: (First) (Last) Agent ID#:

TR K-1 ❑ Referral by Provider ❑ Referred by Member ❑ Company Website ❑ Direct Mail ❑ Self
❑ Local Community Event ❑ Media (TV, News Ad, Mag) ❑ Seminar ❑ Seminar Follow-up

TR K-2 ❑ Personal Appt; Benefit Reply Card (SOA/BRC) ❑ Walk-in (SOA) ❑ Formal Event (Submit)
❑ Application Mailed by Beneficiary ❑ Informal Event (SOA) ❑ Voice Recorded Appt (VRA)

Online/Telephonic Application Confirmation #:

Date Received: Member ID # – 0 1

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 and 1860D-1 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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FREEDOM HEALTH

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.
- ❑ Other: _____

If none of these statements apply to you or you're not sure, please contact Freedom Health at 1-800-401-2740 (TTY users should call 711) to see if you are eligible to enroll. We are open from October 1st to March 31st from 8 a.m. to 8 p.m. EST 7 days a week and from April 1st to September 30th from 8 a.m. to 8 p.m. EST Monday through Friday.

OFFICE USE ONLY

Enrollee's LAST Name: (use boxes below) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

FIRST Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

MI: ☐

Medicare Beneficiary Identifier (MBI): ☐☐☐☐☐☐☐☐☐☐☐

Chronic Special Needs Plan (SNP) Pre-Qualification Form

Special Needs Plan (SNP) is a type of Medicare Advantage coordinated plan focused on individuals with special needs. Freedom Health offers Special Needs Plans (SNPs) designed for people with certain chronic or disabling conditions.

You may be eligible to join one of our chronic-care SNPs if you can answer YES to any of the questions below. Freedom Health will need to obtain verification of the chronic condition from your doctor within 30 days of enrollment. We are required to disenroll you from the special needs plan if we are unable to verify your chronic condition. It is very important, therefore, that you let your doctor know that we will require their verification and that you provide us with accurate contact information for your doctor at the bottom of this form.

CHF/CVD/Diabetes:

Has your doctor or other licensed health care professional diagnosed you with any of the following medical conditions?
(Check all that apply):

Congestive Heart Failure (CHF) ❑ YES ❑ NO Cardiovascular Disease (CVD) ❑ YES ❑ NO Diabetes ❑ YES ❑ NO

CHF:

Do you have fluid in your lungs?	❑ YES ❑ NO
Do you have swelling in your feet and legs almost every day because of too much fluid in your body?	❑ YES ❑ NO
Do you take medicine for the fluid in your lungs or to help your heart beat stronger?	❑ YES ❑ NO

CVD:

Have you had a heart attack or been told by your doctor you are at risk to have one?	❑ YES ❑ NO
Do you have heart pain (angina) or leg pain (claudication) brought on when you are active?	❑ YES ❑ NO
Do you take medicine for your heart or circulation?	❑ YES ❑ NO

Diabetes:

Do you check your blood sugar at home?	❑ YES ❑ NO
Do you have high blood sugar?	❑ YES ❑ NO
Do you take medicine to control your blood sugar?	❑ YES ❑ NO

Chronic Obstructive Pulmonary Disease:

Has your doctor or other licensed health care professional diagnosed you with the following medical condition?

(Check if this applies): Chronic Obstructive Pulmonary Disease (COPD)	❑ YES ❑ NO
Do you have difficulty breathing every day or almost every day even with normal activity?	❑ YES ❑ NO
Do you take medicine to help you breathe better?	❑ YES ❑ NO

Doctor/Health Care Provider Contact Information:

Name of your Doctor or Health Care Provider:

LAST Name: FIRST Name:

Telephone #: Fax #:

Beneficiary Information:

Beneficiary Signature: _____ **Date:** M M D D Y Y Y Y

LAST Name: FIRST Name:

Freedom Health, Inc. is an HMO with a Medicare contract and a contract with the state Medicaid program. Enrollment in Freedom Health, Inc. depends on contract renewal.