Want to keep it easy? Enroll by phone at 1-800-964-4525 (TTY 711) or online at saintalphonsus.org/medicare. If you would rather complete and mail this Enrollment Request Form to us, we have provided instructions below. Follow these easy steps to become a member of Saint Alphonsus Health Plan in 2023:

**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)

**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.

**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.

**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.

**Send your completed and signed form to:**
ATTN ENROLLMENT
MEDICARE HEALTH PLAN
PO BOX 6111
WESTERVILLE OH 43086-9874

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

**Call Saint Alphonsus Health Plan at 1-800-964-4525. TTY users can call 1-800-964-4525 (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 Saint Alphonsus Health Plan al 1-800-964-4525 (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.

- 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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore Maryland 21244-1850.

**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.**
<table>
<thead>
<tr>
<th>Select the plan you want to join:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Saint Alphonsus Health Plan No Premium (HMO), $0 monthly premium</td>
</tr>
<tr>
<td>☐ Saint Alphonsus Health Plan Plus (HMO), $29 monthly premium</td>
</tr>
<tr>
<td>☐ Saint Alphonsus Health Plan Cash Back No Premium 2 (HMO), $0 monthly premium ($50 Part B Buy-Back)</td>
</tr>
<tr>
<td>☐ Saint Alphonsus Health Plan Cash Back No Premium 1 (HMO), $0 monthly premium ($50 Part B Buy-Back)</td>
</tr>
<tr>
<td>☐ Saint Alphonsus Health Plan No Premium Choice (PPO), $0 monthly premium</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FIRST name:</th>
<th>LAST name:</th>
<th>Middle Initial:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Birth date: (MM/ DD/ YYYY)</th>
<th>Sex:</th>
<th>Phone number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(<em><strong>/</strong></em>/_______)</td>
<td>☐ Male ☐ Female</td>
<td>(___)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Permanent Residence street address (Don’t enter a PO Box):</th>
</tr>
</thead>
<tbody>
<tr>
<td>City: County: State: Zip Code:</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<p>| Mailing address, if different from your permanent address (PO Box allowed): |</p>
<table>
<thead>
<tr>
<th>City: State: Zip Code:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Your Medicare information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Number: ___ ___ - ___ ___ - ___ ___</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Answer these important questions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will you have other prescription drug coverage (like VA, TRICARE) in addition to Saint Alphonsus Health Plan? ☐ Yes ☐ No</td>
</tr>
<tr>
<td>Name of other coverage: Member number for this coverage: Group number for this coverage:</td>
</tr>
</tbody>
</table>
IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Saint Alphonsus Health Plan.
- By joining this Medicare Advantage, I acknowledge that Saint Alphonsus 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 Saint Alphonsus Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Saint Alphonsus Health Plan. Benefits and services provided by Saint Alphonsus Health Plan and contained in my Saint Alphonsus Health Plan “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Saint Alphonsus 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.
- With Saint Alphonsus Health Plan HMO plans, I understand that beginning on the date Saint Alphonsus Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Saint Alphonsus Health Plan, with the exception of emergency or urgently needed services or out-of-area dialysis services.
- With a Saint Alphonsus Health Plan PPO plan, I understand that beginning on the date Saint Alphonsus Health Plan coverage begins, out-of-network services will cost more than in-network services with the exception of emergency or urgently needed services or out-of-area dialysis services. When medically necessary, Saint Alphonsus Health Plan covers all covered services including those received out-of-network.
- 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.

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Today’s date</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you’re the authorized representative, sign above and fill out these fields:</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td>Address:</td>
</tr>
<tr>
<td>Phone number:</td>
<td>Relationship to enrollee:</td>
</tr>
</tbody>
</table>
**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.

<table>
<thead>
<tr>
<th>Requested Effective Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optional Medicare Information:</td>
</tr>
<tr>
<td>IS ENTITLED TO: HOSPITAL (PART A) EFFECTIVE DATE ________________</td>
</tr>
<tr>
<td>MEDICAL (PART B) EFFECTIVE DATE ________________</td>
</tr>
<tr>
<td>E-mail Address:</td>
</tr>
</tbody>
</table>

### Optional Dental Plans

*Please note that the Saint Alphonsus Health Plan Cash Back No Premium 1 (HMO) is NOT eligible for the optional dental plans.*

If you’re selecting a Saint Alphonsus Health Plan HMO plan, you may also choose to enroll in one of our optional dental plans for enhanced comprehensive dental coverage (in addition to the preventive and comprehensive dental benefits already included in HMO plans).

- Yes, I would like to enroll in the optional MediGold Dental Silver plan for $21 a month (This is in addition to your Saint Alphonsus Health Plan monthly premium.)
- Yes, I would like to enroll in the optional MediGold Dental Gold plan for $41 a month (This is in addition to your Saint Alphonsus Health Plan monthly premium.)

If you’re selecting a Saint Alphonsus Health Plan PPO plan, you may also choose to enroll in one of our optional dental plans for enhanced comprehensive dental coverage (in addition to the preventive and comprehensive dental benefits already included in PPO plans).

- Yes, I would like to enroll in the optional MediGold Dental Silver plan for $21 a month (This is in addition to your Saint Alphonsus Health Plan monthly premium.)
- Yes, I would like to enroll in the optional MediGold Dental Gold plan for $49 a month (This is in addition to your Saint Alphonsus Health Plan monthly premium.)

### 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, Cuban
- Yes, Puerto Rican
- 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.

Indicate your preferred spoken language (if not English)

- Spanish
- Other

Indicate your preferred written language (if not English):  

- Spanish
- Other

If you need information in another language or accessible format (e.g., large print or braille), contact us at 1-800-964-4525 (TTY:711), 8 AM to 8 PM, seven days a week.
Select one if you want us to send you information in an accessible format.
☐ Braille    ☐ Large print    ☐ Audio CD

Please contact Saint Alphonsus Health Plan at 1-800-964-4525 if you need information in an accessible format other than what’s listed above. Our office hours are 7 days a week, 8 a.m. - 8 p.m. TTY users can call 1-800-964-4525 (TTY 711)

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

Optional:
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: ___________________________ Phone Number: ___________________________
Address: ___________________________ Date you entered this facility: ___________________________
Are you enrolled in your State Medicaid program?    ☐ Yes    ☐ No
If yes, please provide your Medicaid number: ___________________________
Your answer will not keep you from enrolling in this plan.

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

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.

MA-PDs with premiums insert: 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 Saint Alphonsus Health Plan the Part D-IRMAA.

Please select one premium payment option:
☐ Get a bill (monthly billing statement)
☐ Electronic Funds Transfer (EFT) from your bank account each month. If you would like this convenient option, we will mail you a form with instructions on how to complete the process.
☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (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.)

I get monthly benefits from
☐ Social Security
☐ RRB

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 (MARA)”, System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
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 was recently released from incarceration I was released on (insert date).
- I recently returned to the United States after living permanently outside 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). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.
- My plan is experiencing financial difficulties to such an extent that a state or territorial regulatory authority has placed the organization in receivership.
- My plan has been identified by CMS as a consistent poor performer and is identified with a low performing icon (LPI).

I None of these statements apply to me.*

*Please contact Saint Alphonsus Health Plan at 1-800-964-4525 (TTY users should call 711) to see if you are eligible to enroll. We are open 7 days a week, 8 a.m. - 8 p.m.
**Notice of Nondiscrimination**

Saint Alphonsus Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, sex (defined as sex at birth, legal sex and/or sex stereotyping), and gender (which includes gender identity, gender expression and/or pregnancy). Saint Alphonsus Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex or gender. Saint Alphonsus Health Plan:

- Provides free aids and services to people with disabilities 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 services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services.

If you believe that Saint Alphonsus Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Daniel Hayes, Member Services Manager, 3100 Easton Square Place, Third Floor - Health Plan, Columbus, OH 43219, 1-800-240-3851 (TTY 711), 1-833-802-2200 fax, HealthPlanAppeals@trinity-health.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Daniel Hayes, Member Services Manager, 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, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-240-3851 (TTY 711). Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-240-3851 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-240-3851 (TTY 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-240-3851 (TTY 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-240-3851 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d’interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d’assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-240-3851 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên gọi 1-800-240-3851 (TTY 711). sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-240-3851 (TTY 711). Man wird Ihnen dort auf
Deutsch: weiterhelfen. Dieser Service ist kostenlos.


Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-240-3851 (TTY 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة على أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم عربى, ليس عليك سوى الاتصال بنا على 1-800-240-3851 (TTY 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाकिया सेवाएँ उपलब्ध हैं. एक दुभाकिया प्राप्त करने के लिए, बस हमें 1-800-240-3851 (TTY 711). पर फोन करें. कोई व्यक्ति जो हिंदी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-240-3851 (TTY 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Disponemos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-240-3851 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sévis ki gratis.

French Creole: Nou genyen sèvis entèpret gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèpret, jis rele nou nan 1-800-240-3851 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sévis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-240-3851 (TTY 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳 サービスがありますございます。通訳をご用命になるには、1-800-240-3851 (TTY 711). にお電話ください。日本語を話す人 者が支援いたします。これは無料のサー ビスです。

Somali: Waxaan leenahay adeegyo turjumaan oo lacag la'aan ah si aan uga jawaabno su'aalo kasta oo aad ka qabtid caafimaadkayaga ama qorshahayaga daawo ahaaneeed. Si aad u hesho turjumaan, kaliya maga soo wac 1-800-240-3851 (TTY 711). Qof ku hadla luuqada Soomaliga ayaa ku caawin kara. Adeegani waa lacag la'aan.

Form Approved OMB# 0938-1421
Form CMS-10802 (Expires 12/31/25)