



## Medicare Advantage/Medicare Advantage Prescription Drug 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](https://www.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) benefits.

### What happens next?

Send your completed and signed form to:

GlobalHealth  
P.O. Box 1678  
Oklahoma City, OK 73101

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

### How do I get help with this form?

Call GlobalHealth at 1-844-200-8194. 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 GlobalHealth al 1-844-200-8194/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.



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

Select the plan you want to join:

- |  |  |
|--|--|
| <input type="checkbox"/> <b>Global Classic (HMO)</b><br>H9078-001 - \$0 per month                    | <input type="checkbox"/> <b>Global Special Care Savings (HMO C-SNP)</b><br>H9078-010 - \$0 per month |
| <input type="checkbox"/> <b>Global Classic (HMO)</b><br>H9078-003 - \$0 per month                    | <input type="checkbox"/> <b>Global Special Care (HMO C-SNP)</b><br>H9078-007 - \$0 per month         |
| <input type="checkbox"/> <b>Global Special Care Savings (HMO C-SNP)</b><br>H9078-008 - \$0 per month | <input type="checkbox"/> <b>Global Special Care (HMO C-SNP)</b><br>H9078-009 - \$0 per month         |

Last Name: First Name: (Optional) MI:

<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------

Birth Date:  
M M / D D / Y Y Y Y

Sex:  
 Male:  Female:

Home Phone Number:

(Optional) Cell Phone Number:

Permanent Residence Street Address (Do not enter a PO Box):

Street Number: <input type="text"/>	Street Name: <input type="text"/>
--	--------------------------------------

Lot/Apartment: <input type="text"/>	City: <input type="text"/>	State: <input type="text"/>	Zip Code: <input type="text"/>
--	-------------------------------	--------------------------------	-----------------------------------

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

Street Number: <input type="text"/>	Street Name: <input type="text"/>
--	--------------------------------------

Lot/Apartment: <input type="text"/>	City: <input type="text"/>	State: <input type="text"/>	Zip Code: <input type="text"/>
--	-------------------------------	--------------------------------	-----------------------------------

Email Address (Optional):

I want to receive 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 GlobalHealth?**

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:

PCP First Name:

PCP Last Name:

(Optional) MI:

Are you an existing member of this PCP?  Yes  No

**Chronic Special Needs Plans Criteria**

If you are applying for any of the following plans, please fill out "Pre-Enrollment Qualification Assessment Tool" attached at the end of this Application Form.

• **Global Special Care (HMO C-SNP)**

• **Global Special Care Savings (HMO C-SNP)**

**IMPORTANT: Read and Sign Below**

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



**AGENT/OFFICE USE ONLY****Agent Information:**

Last Name:

First Name:

(Optional) MI:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

--

Agency of Agent:

Agent Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**Agent Signature:****Agent Received Date:**

M M / D D / Y Y Y Y

		/			/								
--	--	---	--	--	---	--	--	--	--	--	--	--	--

**Enrollee's Estimated Effective Date:** M M / D D / Y Y Y Y

		/			/								
--	--	---	--	--	---	--	--	--	--	--	--	--	--

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

Last Name:

First Name:

(Optional) MI:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

--

**Election Type:**
 ICEP/IEP
  AEP
  MA OEP
  SEP (type)
 

--	--	--	--	--	--	--	--	--	--	--	--	--	--

 Not Eligible
**Lead Codes:**
 Referral by Provider
  Company Website
  Direct Mail
  Self Generated

 Local Community Event
  Media (TV, News Ad, Mag)
  Seminar
  Seminar Follow-up
**Sale Type:**
 Personal Appt; Business Reply Card (SOA)
  Walk-in (SOA)
  Application Mailed by Beneficiary

 Formal Event (Unique ID):
 

--	--	--	--	--	--	--	--	--	--	--	--	--	--

 Informal

 Voice Recorded Appt (VRA) (Confirmation Number):
 

--	--	--	--	--	--	--	--	--	--	--	--	--	--

Online Telephonic Application Confirmation Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**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."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

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:  /  /  /  /  /
- 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 me 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.

Other

If none of these statements applies to you or you're not sure, please contact GlobalHealth at 1-844-200-8194 (TTY users should call 711) to see if you are eligible to enroll. We are open 8:00 a.m. to 8:00 p.m., 7 days a week (October 1 - March 31) and 8:00 a.m. to 8:00 p.m., Monday - Friday (April 1- September 30).

**AGENT/OFFICE USE ONLY**

**Last Name:**  **First Name:**  **(Optional) MI:**

**Medicare Beneficiary Identifier (MBI):**



## Pre-Enrollment Qualification Assessment Tool

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

You may be eligible to join one of our chronic SNPs if you can answer YES to any of the questions below. Globalhealth 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 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.

### Chronic Heart Failure/Cardiovascular Disorder/Diabetes

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

(Check all that apply)

**Chronic Heart Failure (CHF)**  Yes  No      **Cardiovascular Disorder**  Yes  No

**Diabetes Mellitus**  Yes  No

### Chronic Heart Failure

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

### Cardiovascular Disorder

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



## Beneficiary Information

**Beneficiary Name:**

Last Name:

First Name:

(Optional) MI:

**Birth Date:**

M M / D D / Y Y Y Y

**Medicare ID Number (HICN):**

I authorize the providers listed below to share my health information with GlobalHealth to verify that I have a chronic condition that qualifies me for enrollment in GlobalHealth's chronic special needs plan. This authorization applies to all health information maintained by the provider concerning my medical history for the chronic condition(s) indicated on the first page. Note: GlobalHealth will protect information disclosed as a result of this authorization in accordance with any state and federal laws and requirements that apply. Call us if you have questions or need help with this form. You can reach us at 1-844-200-8194 (TTY: 711). Hours of operation are 8 a.m. to 8 p.m., seven days a week, (October 1 - March 31), and 8 a.m. to 8 p.m., Monday through Friday, (April 1 - September 30). Visit us at anytime at [www.GlobalHealth.com/medicare](http://www.GlobalHealth.com/medicare).

**Enrollee Signature:****Today's Date:** M M / D D / Y Y Y Y**Name of your Doctor or Health Care Provider:**

Last Name:

First Name:

(Optional) MI:

Phone Number:

Fax Phone Number:

**(Optional) Name of your Doctor or Health Care Provider:**

Last Name:

First Name:

(Optional) MI:

Phone Number:

Fax Phone Number: