



# Enrollment 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.

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 collection 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. **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.

## 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:

### By Mail:

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

**By Fax:** 405-280-5455

**By Email:** [brokersupport@globalhealth.com](mailto:brokersupport@globalhealth.com)

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

## How do I get help with this form?

Call GlobalHealth at 1-844-280-5555. 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 1-844-280-5555/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 8 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, 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.

# GlobalHealth

## Section I - All fields on this page are required (unless marked optional)

### Select the plan you want to join:

- Generations Classic Rewards (HMO): \$0 per month
- Generations Valor (HMO-POS)\*: \$0 per month
- Generations Classic Plus (HMO): \$0 per month  
\*(MA Only Plan, No Drug Coverage)

- Generations Chronic Care (HMO C-SNP): \$0 per month
- Generations Chronic Care Savings (HMO C-SNP): \$0 per month
- Generations Dual Support (HMO D-SNP)\*\*: \$0 per month
- Generations Dual Premier (HMO D-SNP)\*\*: \$0 per month  
\*\* (For QMB, QMB+, SLMB+, and FBDE only)

LAST name:

FIRST name:

(Optional) MI:

Sex  
 Male  Female

Birth Date: M M D D Y Y Y Y

Phone Number:

Permanent Residence Street Address: (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.)

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 Directory  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:

FIRST name:

MI:

LAST name:

Are you an existing patient 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#

- Generations Dual Support (HMO D-SNP)
- Generations Dual Premier(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.

- Generations Chronic Care (HMO C-SNP)
- Generations Chronic 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).
- 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).
- 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 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 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 1: (Don't enter a P.O. Box)

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  Audio CD  Braille

Please contact GlobalHealth at 1-844-280-5555 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. 7 days a week and from April 1st to September 30th from 8 a.m. to 8 p.m. Monday through Friday. TTY users can call 711.

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

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

No, Not of Hispanic, Latino/a or Spanish Origin  Yes, Cuban  Yes, Mexican, Mexican American, Chicano/a  
 Yes, Puerto Rican  Yes, another Hispanic, Latino or Spanish Origin  I choose not to answer

What's your race? Select all that apply.

White  Black or African American  American Indian or Alaska Native  Native Hawaiian  Samoan  Other Pacific Islander  
 Asian Indian  Chinese  Filipino  Japanese  Korean  Vietnamese  Other Asian  Guamanian or Chamorro  
 I choose not to answer

What is your gender? Select one:

- Woman  
 Man  
 Non-binary  
 I use a different term: \_\_\_\_\_  
 I choose not to answer

Which of the following best represents how you think of yourself? Select One:

- Lesbian or Gay  
 Straight  
 Bisexual  
 I use a different term: \_\_\_\_\_  
 I don't know  
 I choose not to answer

### 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.

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 GlobalHealth the Part D-IRMAA.

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

Did someone other than a sales agent help your complete this form?

Complete this section if you're an individual (i.e., SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: \_\_\_\_\_ Relationship to enrollee: \_\_\_\_\_

Signature: \_\_\_\_\_

### OFFICE/AGENT USE ONLY:

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

Agent Received Date:

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

Effective Date: (MM/DD/YYYY)

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Agent Signature: \_\_\_\_\_

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

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Not eligible

Agency of Agent: \_\_\_\_\_

Agent Name: (First)

(Last)

Agent ID#:

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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)

Online/Telephonic Application Confirmation #: \_\_\_\_\_

Date Received: \_\_\_\_\_

Member ID #: \_\_\_\_\_

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### 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.