



GlobalHealth
MEDICARE ADVANTAGE PLANS

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

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.

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)*: \$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 Address _____ Lot/Apartment _____
 City: _____ State: _____ Zip Code: _____

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

Street Address _____ 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 ☐ Data CD

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

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. DON'T pay GlobalHealth the Part D-IRMAA.

Did someone other than a sales agent help you 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: _____ National Producer Number (Agents/Brokers only): _____

OFFICE/AGENT USE ONLY:

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

Agent Received Date: _____

Effective Date: (MM/DD/YYYY)

Agent Signature: _____

Election Type: ☐ ICEP/IEP ☐ AEP
☐ MA OEP ☐ SEP (type) _____ ☐ Not eligible

Agency of Agent: _____

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)

Online/Telephonic Application Confirmation #: _____

Date Received: _____

Member ID #: _____

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.