



2020 Enrollment Request Form

Please contact SOLIS Health Plans, Inc. (HMO) if you need information in another language or format (Braille).

To Enroll in SOLIS Health Plans, Please Provide the Following Information:

Please check which plan you want to enroll in:

SOUTH FLORIDA

MIAMI DADE	
<input type="checkbox"/> SPF 001 (HMO) H0982-001	\$0 Premium per month
<input type="checkbox"/> SPF 002 (HMO SNP) H0982-002	\$28.50 Premium per month
BROWARD	
<input type="checkbox"/> SPF 007 (HMO) H0982-007	\$0 Premium per month
PALM BEACH	
<input type="checkbox"/> SPF 008 (HMO) H0982-008	\$0 Premium per month

CENTRAL FLORIDA

ORANGE	
<input type="checkbox"/> SPF 005 (HMO) H0982-005	\$0 Premium per month
<input type="checkbox"/> SPF 006 (HMO SNP) H0982-006	\$28.50 Premium per month
HILLSBOROUGH	
<input type="checkbox"/> SPF 009 (HMO) H0982-009	\$0 Premium per month
<input type="checkbox"/> SPF 010 (HMO SNP) H0982-010	\$28.50 Premium per month

Last Name:	First Name:	Middle Initial:	<input type="checkbox"/> Mr.
			<input type="checkbox"/> Mrs.
			<input type="checkbox"/> Ms.
Birth Date:	MM / DD / YYYY		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Phone Number:	Alternate Phone Number:		
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	County:	State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address):			
City:	County:	State:	ZIP Code:
Emergency contact:	Phone Number:	Relationship to You:	
Email Address:			

Please Provide Your Medicare Insurance Information

Please take out your red, white, and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):	
Medicare Number: (Please use MBI#)	
Is Entitled to:	Effective Date:
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____
You must have Medicare Part A and Part B to join a Medicare Advantage plan.	

Paying Your Plan Premium

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail, Bill Auto Deduction, Electronic Funds Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay SOLIS Health Plans the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium option:

Get a bill

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: Social Security RRB

(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 due 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.)

Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD)? Yes No

If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to SOLIS Health Plans?

Yes No

If "yes", please list your other coverage and your identification (ID) number (s) for this coverage:

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

3. 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 of Institution:
Address of Institution (number and street):	

4. Are you enrolled in your State Medicaid program?

Yes No

If "yes", please provide your Medicaid number: _____

5. Do you or your spouse work?

Yes No

Please choose the name of a Primary Care Physician (PCP), or health center:

PCP Name:	PCP ID:
-----------	---------

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

- Spanish
- Electronic Member Material Document(s)
- Other _____

Please contact SOLIS Health Plans at (844) 447-6547, TTY 711. If you need information in an accessible format or language other than what is listed above.

Our operating hours are:

October 1st to March 31st: 8am to 8pm EST, 7 days a week
April 1st to September 30th: 8am to 8pm EST, Monday-Friday



Please Read This Important Information

If you currently have health coverage from an employer or union, joining SOLIS Health Plans could affect your employer or union health benefits. You could lose your employer or union health coverage if you join SOLIS Health Plans. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

SOLIS Health Plans is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

SOLIS Health Plans serves a specific service area. If I move out of the area that SOLIS Health Plans serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of SOLIS Health Plans, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from SOLIS Health Plans when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date SOLIS Health Plans coverage begins, I must get all of my health care from SOLIS Health Plans, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by SOLIS Health Plans and other services contained in my SOLIS Health Plans Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered.

Without authorization, **NEITHER MEDICARE NOR SOLIS HEALTH PLANS WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with SOLIS Health Plans, he/she may be paid based on my enrollment in SOLIS Health Plans.

Release of Information: By joining this Medicare health plan, I acknowledge that SOLIS Health Plans will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that SOLIS Health Plans will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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 my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (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 from Medicare.

Signature: _____	Today's Date: MM / DD / YYYY
-------------------------	--

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: () _____

Relationship to Enrollee: _____

Agent/Broker Use Only:

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

Plan ID #: _____

Effective Date of Coverage: _____

Election Period (Check One) ICEP/IEP AEP SEP _____ Not Eligible
(type)

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 recently was released from incarceration. I was released on (insert date) _____.
- I recently returned to the United States after living permanently outside of 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.

Please contact SOLIS Health Plans at 1 (844)447-6547, TTY 711. If you need information in an accessible format or language other than what is listed above.

Our operating hours are:

October 1st to March 31st: 8am to 8pm EST, 7 days a week

April 1st to September 30th: 8am to 8pm EST, Monday-Friday

SOLIS Health Plans is a HMO with a Medicare contract. Our SNPs also have contracts with the Florida Medicaid program. Enrollment in SOLIS Health Plans, Inc. (HMO) depends on contract renewal.

Atención: Si usted habla español, servicios de asistencia en español, de forma gratuita, están disponibles para usted. Llame al 1 (844)447-6547 (TTY 711).