SOLIS
HEALTH PLANS

Scope of Appointment Form

To be completed by Medicare Beneficiary (or their authorized representative).

Please initial in the box below beside the plan type that you want the Sales Associate to discuss with you. If you do not want the Sales Associate to discuss a plan type with you, please leave the box empty.

☐ **Medicare Advantage Prescription Drug Plans (Part C & D)**

Medicare Health Maintenance Organization (HMO) - A Medicare Advantage Plan that provides all Original Medicare Part A and B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare Special Needs Plan (SNP) - A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, and people with chronic conditions.

By signing this form, you agree to meet with a Sales Associate to discuss the products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan and may be paid based on your enrollment in a plan. They do not work directly for the Federal Government.

Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

_____	MM / DD / YYYY
Signature	Signature Date

If you are the authorized representative, please sign above and print clearly and legibly below:

Representative's Name:	Relationship to Beneficiary:

H0982_000SCOPE2024_C_082123

Please submit with enrollment form by fax to: 1-305-675-0933 or upload to e-Enroll application.

To be completed by Sales Associate:

Sales Associate Name:	Sales Associate Phone:
Sales Associate ID #:	
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact (Indicate here if beneficiary was a walk-in):	
Sales Associate Signature:	Date Appointment Completed: MM / DD / YYYY
Plan(s) the Sales Associate represented during this meeting:	

Plan use only:

Sales Associate, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:

Solis Health Plans, Inc., is an HMO with a Medicare contract. Enrollment in Solis Health Plans, Inc. (HMO) depends on contract renewal.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-447-6547 (TTY 711).

EXHIBIT 1: Model Individual Enrollment Request Form to Enroll in A Medicare Advantage Plan (Part C)

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** 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) benefit.

What happens next?
Send your completed and signed form to:

By Mail:
Solis Health Plans
9250 NW 36 Street, Suite 400
Doral, Florida 33178

By Fax:
1-305-675-0933

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

How do I get help with this form?
Call Solis Health Plans at 1-844-447-6547. 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 Solis Health Plans al 1-844-447-6547/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.

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.

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.

SOLIS
HEALTH PLANS

Received Date:_____

2024 Enrollment Request Form

Please contact Solis Health Plans if you need information in another language or format (Braille).

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

Please select the plan you want to join:

SOUTH FLORIDA

MIAMI-DADE	
☐ **Solis Healthy Living Plan (HMO)** H0982-022	$0 Premium
☐ **Solis Guardian Plan (D-SNP)** H0982-002	$0-$37.70 Premium
☐ **Solis Wellness Plan (C-SNP)** H0982-016	$0 Premium
BROWARD	
☐ **Solis Healthy Living Plan (HMO)** H0982-007	$0 Premium
☐ **Solis Guardian Plan (D-SNP)** H0982-012	$0-$37.70 Premium
☐ **Solis Wellness Plan (C-SNP)** H0982-017	$0 Premium
PALM BEACH	
☐ **Solis Healthy Living Plan (HMO)** H0982-008	$0 Premium
☐ **Solis Guardian Plan (D-SNP)** H0982-013	$0-$37.70 Premium
☐ **Solis Wellness Plan (C-SNP)** H0982-018	$0 Premium

CENTRAL FLORIDA

HILLSBOROUGH	
☐ **Solis Healthy Living Plan (HMO)** H0982-009	$0 Premium
☐ **Solis Guardian Plan (D-SNP)** H0982-010	$0-$37.70 Premium
☐ **Solis Wellness Plan (C-SNP)** H0982-019	$0 Premium
PINELLAS	
☐ **Solis Healthy Living Plan (HMO)** H0982-009	$0 Premium
☐ **Solis Wellness Plan (C-SNP)** H0982-019	$0 Premium
POLK	
☐ **Solis Healthy Living Plan (HMO)** H0982-020	$0 Premium
☐ **Solis Wellness Plan (C-SNP)** H0982-021	$0 Premium

Section 1–All fields on this page are required (unless marked optional)			
First Name:	Middle Initial: (Optional)	Last Name:	
Birth Date: (MM/DD/YYYY)	Sex: ☐Male ☐Female ☐Other:_____	Phone Number: Email:	
Permanent Residence Street Address: (PO Box is not allowed) ☐Experiencing Homelessness			
City:	County:	State:	Zip Code:
Mailing Street Address: (PO Box is allowed)			
City:	County:	State:	Zip Code:

Your Medicare Information	
Medicare Number:	Effective Date Part A:_____ Effective Date Part B:_____

Your PCP Information
Name of your Primary Care Physician (PCP):
PCP ID: (Please include all digits)
Name of Clinic or Health Center:
Are you already a patient of this physician you chose?: ☐Yes ☐No ☐Other:_____

Answer These Important Questions		
Will you have other prescription drug coverage (like VA, TRICARE) in addition to Solis?: ☐Yes ☐No		
If you answered yes to the above, please fill out the information below:		
Name of other coverage:	Member number for this coverage:	Group number for this coverage:

For Special Need Plans (SNP) Only

Solis Offers Two SNPs:
D-SNPs for dual eligible individuals and **C-SNPs** for individuals with Chronic Conditions.
D-SNPs are **SNPs** that restrict enrollment to individuals who are entitled to both Medicare and medical assistance from a state plan under Medicaid.

Do have Medicaid or receive assistance from a state plan under Medicaid?

☐ Yes ☐ No **Medicaid ID #:** _____

C-SNPs are **SNPs** that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions.

Have you ever been diagnosed with Congestive Heart Failure (CHF), Cardiovascular disease (CVD) and/or Diabetes? ☐ Yes ☐ No

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.

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

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **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.**

Please check one of the boxes below if you would prefer that we send you information in another language or in an accessible format:

- ☐ Spanish
- ☐ Braille
- ☐ Creole
- ☐ Other: _____

Please contact **Solis Health Plans at** 1-**844-447-6547** if you need information in an accessible format other than what's listed above. We're available from October 1 - March 31, 7 days a week; 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday from 8 a.m. to 8 p.m.

Do you or your spouse work?: ☐ **Yes** ☐ **No**

Do you have other health insurance that will cover medical services? (Examples: other employer coverage, LTD coverage, worker's compensation, auto liability, or VA benefits? If yes, please provide the following information:

Name of Health Insurance Company: _____

Member Number: _____

I want to receive the following materials via email:

Email Address: _____

Select one or more:

☐ Evidence of Coverage ☐ OTC Catalog ☐ Formulary

Paying your plan premium:

You can pay your monthly plan premium (including any late enrollment penalty that you currently or may owe) by mail. **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.**

☐ Get a bill ☐ Deduction from Social Security ☐ Deduction from RRB

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. DO NOT pay Solis Health Plans the Part D-IRMAA.

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.

IMPORTANT: Read and Sign Below

- I must keep both Hospital (Part A) and Medical (Part B) to stay enrolled in Solis Health Plans.

- By joining this Medicare Advantage Plan, I acknowledge that Solis Health Plans 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. (Exception apply for MA PFFS, MA MSA plans.)

- I understand that when my Solis Health Plans coverage begins, I must get all of my medical and prescription drug benefits from Solis Health Plans. Benefits and services provided by Solis Health Plans and contained in my Solis Health Plans "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Solis Health Plans 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.

- 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:
X	

AUTHORIZED REPRESENTATIVE INFORMATION ONLY			
If you're the authorized representative, sign above and fill out these fields.			
First Name:		**Last Name:**	
Address:			
City:	**State:**	**Zip Code:**	**Phone Number:**
Email:		**Relationship to Enrollee:**	
☐ **I have submitted Authorized Representative documentation with this application.**			

To be completed by Sales Associate:

Sales Associate Name:	Sales Associate Phone:
Sales Associate ID #:	
Sales Associate Signature:	Date Appointment Completed: MM / DD / YYYY

Please ensure you include/submit the Scope of Appointment together with the completed Enrollment Application.

You may send both (Scope of Appointment with Enrollment Application) via fax to 305-675-0933 or you can email both (Scope of Appointment with Enrollment Application) to Sales@SolisHealthPlans.com.

Solis Health Plans is an HMO with a Medicare contract. Enrollment in Solis Health Plans, Inc. (HMO) depends on contract renewal.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-447-6547 (TTY 711).

Election Periods

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.

- ☐ (IEP/ICEP/IEP2) I am new to Medicare.
- ☐ (AEP) Annual Enrollment Period (October 15 - December 7).
- ☐ (MA OEP) I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (January 1 - March 31).
- ☐ I recently moved outside of the service area for my current plan, or 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 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 chance 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). I moved/will move into/out of the facility on (insert date)_____. If moving in, name of facility:_____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date)_____.
- ☐ My plan is ending its contract with Medicare (or my State) and I want to choose a different plan. My enrollment in that plan started on (insert date)_____.
- ☐ I want to join a Special Needs Plan (C-SNP) that tailors its benefits to my chronic condition.
- ☐ I was enrolled in a Special Needs Plan (DSNP/C-SNP) but I have lost the special needs qualification required to be in that plan. (insert date)_____.
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency FEMA) or by Federal, State, or Local Government entity. One of the other statements here applied to me, but I was able to make my enrollment request because of the disaster.
- ☐ Other:_____

If you need information in an accessible format or language other than what is listed above, please contact Solis Health Plans at 1-844-447-6547 (TTY: 711). From October 1 - March 31, we are open 7 days a week; 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday from 8 a.m. to 8 p.m. Solis Health Plans Inc. is an HMO plan with a Medicare contract. Enrollment in Solis Health Plans, Inc. depends on contract renewal. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-447-6547 (TTY: 711).

SOLIS HEALTH PLANS

CHRONIC SPECIAL NEEDS PRE-QUALIFICATION ASSESSMENT FORM

Please fax this form to: 305-675-0933

Or call Toll Free: (844) 447-6547 9250 NW 36th Street, Suite 400 • Doral, FL 33178

Solis Health Plans, Inc., is a Medicare Advantage Organization that offers various types of health plans. A Special Needs Plan (SNP) is a type of Medicare Advantage coordinated plan focused on individuals with special needs. The Solis Chronic Special Needs Plan (C-SNP) is offered to people with certain chronic or disabling conditions: **Cardiovascular Disease (CVD), Congestive Heart Failure (CHF), and Diabetes Mellitus (DM).**

You may be eligible to join the C-SNP if you can answer "YES" to any of the questions below. Solis will need to obtain verification of the chronic condition from your doctor within 30 days of enrollment. Please submit this completed pre-qualification form with your enrollment application.

Solis is required to disenroll you from the C-SNP on the second month of enrollment if we are unable to verify your chronic condition. It is very important, therefore, that you let your doctor know that we will require their verification and that you provide us with accurate contact information from your doctor in the appropriate area of this form. If you answer "NO" to all of the questions indicating you do not have any of the qualifying conditions, you will not be eligible for this C-SNP.

BENEFICIARY IDENTIFYING INFORMATION

Beneficiary's Name:

MBI #: Date of Birth: / /

PRE-QUALIFYING QUESTIONS

If the applicant answers "YES" to any of the following questions, then the beneficiary pre-qualifies for the C-SNP.

Cardiovascular Disease/Congestive Heart Failure:

1. Have you had or been told you're at risk of having a heart attack? ☐ Yes ☐ No
2. Have you received a stent in your heart? ☐ Yes ☐ No
3. Do you have a pacemaker, or do you take any medications for abnormal heart rhythm? ☐ Yes ☐ No
4. Has your doctor told you that you have reduced blood flow to your legs or feet? ☐ Yes ☐ No
5. Have you ever had a procedure to improve blood supply to your legs or feet? ☐ Yes ☐ No
6. Do you suffer from blood clots, or are you taking any long-term medications for blood clots? ☐ Yes ☐ No
7. Do you take any medications for your heart or circulation? ☐ Yes ☐ No
8. Has your doctor told you that your heart is not pumping as well as it should? ☐ Yes ☐ No
9. Do you have swelling in your feet and legs almost every day due to too much fluid in your body? ☐ Yes ☐ No
10. Do you take a water pill due to a heart-related condition (such as heart failure)? ☐ Yes ☐ No
11. Do you take medication for the fluid in your lungs or to help your heart beat stronger? ☐ Yes ☐ No

Diabetes Mellitus:

1. Do you regularly check your blood sugar at home? ☐ Yes ☐ No
2. Have you been diagnosed with high blood sugar (diabetes)? ☐ Yes ☐ No
3. Do you take any medications to control your blood sugar? ☐ Yes ☐ No

PRIMARY CARE PROVIDER INFORMATION

Primary Care Provider Name:

Provider Address: Provider Telephone:

PROVIDER'S INFORMATION

Do you have any specialist(s) that you see for the Chronic Conditions specified in this form? ☐ Yes ☐ No

Provider's Name:

Provider's Address: Provider's Telephone:

Applicant's Signature: _____ Date: _____

Time of Signature: _____ a.m/p.m

Caregiver's Signature: _____ Date: _____

Agent/Broker's Name (Print): _____

Agent/Broker's Signature: _____ Date: _____

PROVIDER REVIEW AND STATEMENT

I am a provider for the above stated patient. I have reviewed the above form and agree that the patient has one of the qualifying conditions necessary for enrollment into the C-SNP. The patient has been diagnosed with (select all that apply):

Cardiovascular Disease (CVD) ☐ Yes ☐ No

Congestive Heart Failure (CHF) ☐ Yes ☐ No

Diabetes Mellitus ☐ Yes ☐ No

I understand that without verifying the diagnosis, the patient will not be allowed to enroll in the C-SNP with Solis Health Plans.

Provider's Name (Print): _____ Credentials: (MD, DO, APRN, PA)

Signature: _____ Date: _____

NPI: _____ Telephone: _____

Solis Health Plans, Inc., is an HMO with a Medicare contract. Enrollment in Solis Health Plans, Inc. depends on contract renewal.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-447-6547 (TTY 711).

SOLIS
HEALTH PLANS

2024 Enrollment Receipt

Note to Sales Associate: Complete and leave with enrollee.

Thank you for choosing Solis Health Plans! Keep this as proof of enrollment until Medicare confirms your enrollment and you receive your new member materials. This receipt is not a guarantee of enrollment.

This receipt is for your records only. No further action is necessary.

Applicant

Name:	
Proposed Effective Date: MM / DD / YYYY	Application Date: MM / DD / YYYY
Plan Name:	Plan Type:

Your Sales Associate is available to assist you if you have any questions:

Sales Associate Name:	
Sales Associate Phone Number:	Sales Associate ID:

If you have any questions you can call Member Services at 1-844-447-6547 (TTY: 711). From October 1 - March 31, we are open 7 days a week; 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday from 8 a.m. to 8 p.m.

Solis Health Plans, Inc., is an HMO with a Medicare contract. Enrollment in Solis Health Plans, Inc., (HMO) depends on contract renewal. ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-844-447-6547 (TTY: 711).

H0982_000RECEIPT2024_C_082623