SOLIS
HEALTH PLANS

Scope of Appointment Form

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

Please initial below in the box 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, people who reside in nursing homes.

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:

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:

Scope of Appointment (SOA) is subject to CMS Record Retention Requirements. SOLIS Health Plans is an HMO plan with a Medicare contract. Our SNPs also have contracts with the Florida Medicaid program. Enrollment in SOLIS Health Plans depends on contract renewal.

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 January1)
- 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.

SOLIS
HEALTH PLANS

2023 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	
☐ **SPF 001 (HMO)** H0982-001	$0 Premium per month
☐ **SPF 002 (D-SNP)** H0982-002	$35.90 Premium per month
☐ **SPF 003 (HMO)** H0982-014	$0 Premium per month
☐ **SPF 004 (D-SNP)** H0982-015	$35.90 Premium per month
☐ **SPF 011 (C-SNP)** H0982-011	$35.90 Premium per month
BROWARD	
☐ **SPF 007 (HMO)** H0982-007	$0 Premium per month
☐ **SPF 012 (D-SNP)** H0982-012	$35.90 Premium per month
PALM BEACH	
☐ **SPF 008 (HMO)** H0982-008	$0 Premium per month
☐ **SPF 013 (D-SNP)** H0982-013	$35.90 Premium per month

CENTRAL FLORIDA

HILLSBOROUGH	
☐ **SPF 009 (HMO)** H0982-009	$0 Premium per month
☐ **SPF 010 (D-SNP)** H0982-010	$35.90 Premium per month

OMB No. 0938-1378
Expires:7/31/2024

Section1–All fields on this page are required (unless marked optional)

Select the plan you want to join:

☐ Product HMO - $0 per month ☐ Product SNP - $35.90 per month

FIRST name: LAST name: (OPTIONAL) Middle Initial:

Birth date: (MM/DD/YYYY) (_ _ / _ _ / _ _ _ _)	Sex: ☐ Male ☐ Female	Phone number: ( )

Permanent Residence street address (Don't enter a PO Box):

City:	(Optional) County:	State:	ZIP Code:

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

Street address: City: State: ZIP Code:

Your Medicare information:

Medicare Number: _ _ _ _-_ _ _-_ _ _ _

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Solis? ☐ Yes ☐ No

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 chronic-condition individuals
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 you 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.

Do you have a Chronic and disabling mental health condition, like Bipolar disorder, Major depressive disorder, Paranoid disorder, Schizophrenia or Schizo-affective disorder?

☐ Yes ☐ No

OMB No. 0938-1378
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IMPORTANT: Read and sign below:

- I must keep Hospital (Part A) or Medical (Part B) to stay 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 PrivacyAct Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.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 thisapplication means that I have read and understand the contents of this application. If signed by an authorizedrepresentative (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:**
If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

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Section2–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, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **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.**

Select one if you want us to send you information in a language other than English:

☐ Spanish ☐ Other:_____

Select one if you want us to send you information in an accessible format:

☐ Braille ☐ Large Print ☐ Audio CD

Please contact Solis Health Plans at (844) 447-6547 if you need information in an accessible format other than what's listed above. Our office hours are October 1st to March 31st: 8am to 8pm EST, 7 days a weekApril 1st to September 30th: 8am to 8pm EST, Monday-Friday. TTY users can call 711.

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

List your Primary Care Physician (PCP), clinic, or health center: _____

PCP ID: _____

I want to get the following materials via email. Select one or more:

- ☐ Evidence of Coverage
- ☐ Provider Directory
- ☐ Dental Benefits
- ☐ Formulary
- ☐ OTC Catalog
- ☐ Provider Directory

Email address: _____

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. **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.
DON'T 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) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

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.
- [ ] Other _____.

Please contact Solis Health Plans at 1 (844)447-6547, TTY 711. If you need information in an accesible 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 Inc. is an HMO plan with a Medicare contract. Enrollment in Solis Health Plans, Inc. depends on contract renewal.

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

	SEP Group	SEP Reason Code Description
☐	General	SEP for providing individuals who requested materials in accessible formats equal time to make enrollment decisions.
☐	General	For involuntary loss of creditable prescription drug coverage. (insert date)
☐	General	Individuals who disenroll in connection with a CMS sanction.
☐	General	Individuals may disenroll from a Part D Plan (PDP, MA-PD) to enroll in or maintain other credible drug coverage. May disenroll from MA-PD by enrolling in MA-only plan.
☐	General	Disenroll from an MA/MAPD/PDP to enroll in PACE or PACE disenroll to enroll in MA/MAPD. (insert date)
☐	General	Individuals enrolled in Cost Plans that are non-renewing their contracts.
☐	General	Enrollment into a C-SNP and for individuals found ineligible for a C-SNP.
☐	General	Individuals whose Medicare entitlement determination was made retroactively.
☐	General	Individuals who enroll in Part B during the Part B General Enrollment Period (GEP). (MA_PD and PDP). Individuals who have Parts A and B for the first time are eligible for ICEP.
☐	General	Individuals enrolled in a SNP who are no longer eligible for the SNP because they no longer meet the specific special needs status (insert date)
☐	General	Non-U.S. citizens who become lawfully present. (insert date)
☐	General	Individuals who belong to a qualified SPAP or who lose SPAP eligibility.
☐	General	Individuals enrolled in a Plan offered by an MA or PDP organization that is placed into receivership by a State or territorial regulatory authority.
☐	General	This SEP exists while the individual is enrolled in the low performing MA or PDP Plan. (Plan with a star rating of less than 3 stars for the last 3 years.)

	SEP Group	SEP Reason Code Description
☐	Emergency or Disaster	Government entity-declared disaster or other emergency.
☐	Emergency or Disaster	Government entity-declared disaster or other emergency related to COVID-19.
☐	Terminations	CMS initiated termination of contract. Includes contract term by CMS, and immediate term by CMS where CMS provides notice of term to a Plan's members and the term may be mid-month.
☐	Terminations	Plan initiated terminations/contract modifications by mutual consent. Includes contract non-renewals, Plan service area reductions, term/mod of contract by mutual consent.
☐	CMS Approval Required	CMS determined that the beneficiary was not adequately informed of the creditable status of drug coverage provided by a Plan required to give such notice, or a loss of creditable coverage. Permits enrollment in MA-PD or PDP only. (Different from marketing mis-representation).
☐	CMS Approval Required	CMS determines that changes to a plan's provider network are significant based on the affect, or potential to affect current plan enrollees.
☐	CMS Approval Required	CMS determined the individual is able to demonstrate to CMS that the MA/MA-PD/PDP organization of which he/she is a member substantially violated a material provision of its contract.

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SOLIS
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2023 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 Toll-Free at 1-844-447-6547 (TTY: 711). Please allow 7 business days for us to process your application. Hours of Operation: October 1st - March 31st, 8 a.m. to 8 p.m., 7 days a week, April 1st - September 30th, 8 a.m. to 8 p.m. Monday to Friday.

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