Kansas Health Advantage
201 Jordan Road, Suite 200
Franklin, TN 37067
1-800-399-7524 (TTY/TDD: 711)
KansasHealthAdvantage.com

Kansas Health Advantage Individual Enrollment Request Form

Please contact Kansas Health Advantage if you need information in another language or format (Large Print).

To Enroll in Kansas Health Advantage, Please Provide the Following Information:

Please check which plan you want to enroll in:
_____Kansas Health Advantage (HMO I-SNP) $31.50 per month [H2392-001]
_____Kansas Health Advantage Plus (HMO I-SNP) $180.00 per month [H2392-002]

LAST name	FIRST Name	Middle Initial	☐ Ms. ☐ Mr. ☐ Mrs.

Birth Date (MM/DD/YYYY)	Sex ☐ M ☐ F	Home 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):

Street Address	City	State	ZIP Code

Emergency contact	**Phone Number**	**Relationship to You**

E-mail 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: _____

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

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 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 RRB. DO NOT pay Kansas Health Advantage 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 payment option:

☐ Get a bill each month

☐ 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 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 any more, **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 Kansas Health Advantage?
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: _____

Address & Phone Number 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

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

_____

7. 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:

____ Español (Spanish)

____ Large print

Please contact Kansas Health Advantage at 1-800-399-7524 if you need information in an accessible format or language other than what is listed above. Our office hours are 8:00 a.m. to 8:00 p.m. seven days a week (except Thanksgiving and Christmas) from October 1 through March 31; 8:00 a.m. to 8:00 p.m. Monday to Friday (except holidays) from April 1 through September 30. TTY/TDD users should call 711.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Kansas Health Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Kansas Health Advantage. 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:

Kansas Health Advantage 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.

Kansas Health Advantage serves a specific service area. If I move out of the area that Kansas Health Advantage 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 Kansas Health Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Kansas Health Advantage 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 Kansas Health Advantage coverage begins, I must get all of my health care from Kansas Health Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Kansas Health Advantage and other services contained in my Kansas Health Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR KANSAS HEALTH ADVANTAGE 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 Kansas Health Advantage he/she may be paid based on my enrollment in Kansas Health Advantage.

Release of Information: By joining this Medicare health plan, I acknowledge that Kansas Health Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Kansas Health Advantage 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:**

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

Name: _____

Address: _____

Phone Number: (___) ____- _____

Relationship to Enrollee _____

Kansas Health Advantage, offered by Kansas Superior Select, Inc, is a Health Maintenance Organization (HMO) with a Medicare contract. Enrollment in Kansas Health Advantage depends on contract renewal.

Out of network/non-contracted providers are under no obligation to treat Kansas Health Advantage members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

English
Kansas Health Advantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

If you, or someone you're helping, has questions about Kansas Health Advantage, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-399-7524 (TTY/TDD: 711).

Español (Spanish)
Kansas Health Advantage cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Kansas Health Advantage, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame a l -800-399-7524 (TTY/TDD: 711).

Tiếng Việt (Vietnamese)
Kansas Health Advantage tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Kansas Health Advantage, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-800-399-7524 (TTY: 711).

Office Use Only:

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

Plan ID #:_____

Effective Date of Coverage: _____

ICEP/IEP:_____AEP:_____SEP (type):_____Not Eligible: _____