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# INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C) OR MEDICARE PRESCRIPTION DRUG PLAN (PART D)

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## Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug 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.

## 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:

**Liberty Medicare Advantage  
PO Box 3630  
Little Rock, AR 72202**

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

## How do I get help with this form?

Call Liberty Medicare Advantage at 1-844-854-6884. 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 Security Health Plan al 1-844-854-6884/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.

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-NEW. 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.



**2022 Enrollment Request**

**Section 1 - All fields on this page are required (unless marked optional)**

To enroll in a Liberty Medicare Advantage plan, please provide the following information. Liberty Medicare Healthy at Home, is offered by Liberty Advantage, LLC dba Liberty Medicare Advantage.

**Select the plan you want to join:**  
 Liberty Medicare Healthy at Home (HMO I-SNP) \$0 per month

FIRST name	LAST name	Middle initial
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<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Birthdate (mm/dd/yyyy) ____ / ____ / ____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
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Phone number (____) _____ - _____	Alternate phone number (____) _____ - _____
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Permanent residence street address (Don't enter a PO Box)

City	County	State	ZIP Code
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Mailing address, if different from your permanent address (PO Box allowed)

Street address	City	State	ZIP code
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Email address (used to communicate Plan information)

**Your Medicare Information**

Medicare number      \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Answer these important questions:**

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Liberty Medicare Advantage?    Yes    No

Name of other coverage:      Member number for this coverage:      Group number for this coverage

\_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_

Do you reside in a long-term facility, such as a nursing home?    Yes    No

Name of Facility: \_\_\_\_\_

I reside in my home and require institutional level of care

**IMPORTANT: Read and Sign below:**

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Liberty Medicare Healthy at Home.
- By joining this Medicare Advantage Plan, I acknowledge that Liberty Medicare Healthy at Home 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.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Liberty Medicare Healthy at Home coverage begins, I must get all of my medical and prescription drug benefits from Liberty Medicare Healthy at Home. Benefits and services provided by Liberty Medicare Healthy at Home and contained in my Liberty Medicare Healthy at Home “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Liberty Medicare Healthy at Home 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
- Liberty Medicare Healthy at Home serves a specific service area. If I move out of the area that Liberty Medicare Healthy at Home 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 Liberty Medicare Healthy at Home, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Liberty Medicare Healthy at Home when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.
- I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Liberty Medicare Healthy at Home, he/she may be paid based on my enrollment in Liberty Medicare Healthy at Home.

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

<b>Signature:</b>	<b>Today's date:</b>
If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

**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.**

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

Espanol

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

Braille

Large print

Audio CD

Please contact Liberty Medicare Advantage at 1-844-854-6884 if you need information in an accessible format other than what's listed above. Our office hours are 8:00 a.m. to 8:00 p.m. 7 days a week. 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:

I want to get the following materials via email.

Summary of Benefits

Email address:

**Paying your plan premiums**

You can pay your monthly plan premium \$0 (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 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.** The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). **DON'T** pay Liberty Medicare Advantage 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.

**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: \_\_\_\_\_

OEPI: \_\_\_\_\_ MA OEP: \_\_\_\_\_

Date Received: \_\_\_\_\_