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2021 Enrollment Book

Diabetes & Heart Care (HMO CSNP)

2021 HealthTeam Advantage Enrollment Instructions

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. and live in the plan's service area. You must also have Medicare Part A and Part B.

What You'll Need

- Your red, white, and blue Medicare insurance card
- Your health insurance information for any other insurance you have
- Your primary care provider's full name

Tips for Enrollment

- Each applicant must complete their own enrollment. Don't photocopy a form for reuse.
- Print neatly. You must complete all items.
- Make a copy of the application for your records.
- We recommend you confirm your form was received if you fax or mail it (e.g. send certified mail).

How to Enroll in HealthTeam Advantage

Online: Visit HealthTeamAdvantage.com or the Centers for Medicare & Medicaid Services website at Medicare.gov.

Phone: Call one of our professional sales agents at 877-905-9216 October 1–March 31, 8 a.m. to 8 p.m. ET, seven days a week, or April 1–September 30, 8 a.m. to 8 p.m. ET, Monday through Friday to enroll over the phone or to schedule a personal meeting.

Independent Agent: Contact your local insurance agent who is certified to sell HealthTeam Advantage plans.

Fax: Complete the enclosed Enrollment Form and fax to HealthTeam Advantage at 800-905-9131.

Mail: Complete the enclosed Enrollment Form and mail back to HealthTeam Advantage in the provided post-paid envelope located at the end of this book.

Reminder: 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.

Once your request to join has been processed, HealthTeam Advantage will contact you.

Need Help?

Call 877-905-9216 October 1–March 31, 8 a.m. to 8 p.m. ET, seven days a week, or April 1–September 30, 8 a.m. to 8 p.m. ET, Monday through Friday.

Scope of Sales

Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or their authorized representative.

Please initial below beside the type of products(s) you want the agent to discuss.

	MEDICARE ADVANTAGE PLANS (PART C)

Medicare Health Maintence Organizatin (HMO) Plan—A Medicare Advantage Plan provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. HMOs have network doctors and hospitals from which you must get your care and services.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the federal government. This individual may also be paid based on your enrollment in a plan.

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

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: _____ Date: _____

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

Representative's Name: _____

Your Relationship to the Beneficiary:_____

To be completed by Agent:

Plan(s) the agent represented during this meeting: _____

Agent Name: _____ Agent Phone:_____

Beneficiary Name:_____ Beneficiary Phone: _____

Beneficiary Address:_____
(optional)

Initial Method of Contact: _____
(Indicate here if beneficiary was a walk-in.)

Date Appointment Completed: _____

*Scope of Appointment documentation is subject to CMS record retention requirements

Individual Enrollment Application Form
2021 Plan Year

Important Information

Please check which plan you want to enroll in:

MA-PD Plans:

☐ HealthTeam Advantage Diabetes & Heart Care HMO CSNP $0 per month

Optional Supplemental Benefits Riders:

☐ HealthTeam Advantage Comprehensive Dental Rider $25 per month

Last Name:	First Name:	Middle Initial:	☐ Mr. ☐ Ms. ☐ 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:	County:	State:	ZIP Code:

Emergency Contact:	Phone Number:	Relationship to You:

Email Address:

Please Provide Your Medicare Insurance Information

Medicare Number: _____

Hospital (Part A) Effective Date: _____ Medical (Part B) Effective Date: _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Individual Enrollment Application Form 2021 Plan Year, continued

Paying Your Plan Premium

1. You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT), or credit card 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 HealthTeam Advantage the Part D-IRMAA.

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

Please select a premium payment option:

☐ Get a bill monthly

☐ Electronic funds transfer (EFT) from your bank account each month.
Please enclose a VOIDED check or provide the following:

Account Holder Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Account type: ☐ Checking ☐ Savings

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.)*

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 the HealthTeam Advantage Health Plan? ☐ **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 _____

Important Information

3. Do you or your spouse work? ☐ **Yes** ☐ **No**

Please choose the name of a Primary Care Provider (PCP):

_____

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: ☐ **Large Print** ☐ **Other**

Please contact HealthTeam Advantage at 1-888-965-1965, if you need information in another accessible format or language other than what is listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week (ET) from October 1 to March 31, and 8 a.m. to 8 p.m. Monday through Friday, from April 1 to September 30. TTY users should call 711.

4. IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in HealthTeam Advantage.
- By joining this Medicare Advantage Plan, I acknowledge that HealthTeam Advantage 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 HealthTeam Advantage coverage begins, I must get all of my medical and prescription drug benefits from HealthTeam Advantage. Benefits and services provided by HealthTeam Advantage and contained in my HealthTeam Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor HealthTeam Advantage will pay for benefits or services that are not covered.
- If you currently have health coverage from an employer or union, joining HealthTeam Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join HealthTeam 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.

Individual Enrollment Application Form 2021 Plan Year, continued

- 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:

_____

Signature **Date**

If you're the authorized representative, sign and fill out these fields. This person is authorized under state law to complete this enrollment, and documentation of this authority is available upon request by Medicare.

Name: _____

Relationship to Enrollee: _____

Address: _____

_____

Phone Number: _____

Office Use Only:

_____

Name of agent/broker (if assisted in enrollment) NPN

_____

Plan ID# Effective Date of Coverage

Date Application Received by Agent: _____

ICEP/IEP: _____ AEP: _____ OEP: _____ SEP (type): _____ Not Eligible: _____

Chronic Condition Verification Form

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal law concerning the privacy of such information.

Release of Information

By joining HealthTeam Advantage (HTA), a Medicare Advantage Special Needs Plan for Chronic Conditions, I acknowledge that I have one or more of the following conditions:

☐ **Diabetes** ☐ **Chronic Heart Failure**

I authorize and direct _____ (Care Provider/Specialist) to confirm my chronic condition and disclose my medical records to HTA. This authorization shall be effective until I am no longer enrolled in HTA.

Application Use and Disclosure Authorization

APPLICANT, please complete if applicable.

Print Name of Applicant/Authorized Representative: _____

Medicare ID Number or Date of Birth: _____

Signature of Applicant/Authorized Representative: _____ Date: _____

If you are the authorized representative of the applicant, provide the following information:

Relationship to Applicant: _____ Telephone Number: _____

Provider Confirmation of Chronic Condition

CARE PROVIDER/SPECIALIST, please complete.

I, _____ (Care Provider/Specialist),

hereby certify that _____ (Applicant)

has the following health condition(s):

☐ **Diabetes** ☐ **Chronic Heart Failure**

Care Provider/Specialist Signature: _____ **Date:** _____

Fax this completed form to: 800-820-0774

Mail this form to: HealthTeam Advantage, 7800 McCloud Road, Suite 100, Greensboro, NC 27409
If you have any questions, please call: 877-905-9216, TTY 711, Monday—Friday, 8:00 a.m.—5:00 p.m.

Application Checklist

Here's a quick check list to review your application and to keep for your records.

___ 1. The agent reviewed the HealthTeam Advantage Summary of Benefits for all HealthTeam Advantage plans.

___ 2. I selected the HealthTeam Advantage plan that best fits my current Medicare needs.

___ 3. I understand that the plan I have chosen is NOT a Medicare supplement (Medigap) plan.

___ 4. The agent explained the assistance a HealthTeam Advantage Healthcare Concierge can provide.

___ 5. The agent reviewed prescription drug (Rx) needs and identified the tiers and related co-pays using the Drug List. The agent explained the Rx benchmark, 2021 coverage gap, new changes once the coverage gap is reached, step therapy (if required), late enrollment penalty, and prior authorization.

___ 6. The agent explained I must continue to pay the Medicare Part B premium.

___ 7. The agent gave me the following materials:

A. HealthTeam Advantage Summary of Benefits C. Business Card

B. Multi-Language Insert

___ 8. I understand that the Primary Care Provider I have chosen is _____

and the physician is currently ☐ In-network ☐ Out-of-network

**Network participation may change*

___ 9. The payment method I have selected is ☐ Monthly Invoice ☐ SSA Deduct ☐ ACH

OPTIONAL SUPPLEMENTAL COVERAGE:

___ 10. The agent reviewed the HealthTeam Advantage Comprehensive Dental Rider with me. If selected, the agent explained that this optional coverage requires an additional $25 monthly premium.

Receipt

This receipt verifies that you completed an enrollment form with an agent who sells HealthTeam Advantage Medicare Advantage health plans.

Important Enrollment Info

Application Date: _____

Proposed Effective Date: _____

Medicare ID: _____

Plan Name: _____

Sales Agent Name: _____

Sales Agent Phone: _____

Sales Agent ID: _____

Thank You for Enrolling in HealthTeam Advantage!

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What's Next?

The following next steps will help you better understand what to expect on your way to becoming a HealthTeam Advantage Member.

The day you enroll…

- Receipt of completed enrollment form: The agent will provide a receipt that confirms you submitted an enrollment form. If you enroll online, you will receive a confirmation number and you will have the ability to print an electronic copy of your completed application for your files.

Within 10 days of submitting enrollment form…

- Letter confirming receipt of your enrollment and enrollment approval from Medicare to the HealthTeam Advantage plan you selected.

When you become a HealthTeam Advantage member…

- **HealthTeam Advantage Evidence of Coverage:** This book is your detailed coverage of your plan.
- **HealthTeam Advantage member identification card:** You will receive your HealthTeam Advantage member identification card.
- **Personal Healthcare Concierge at your service:** If you would like assistance finding a provider, scheduling an appointment, have questions about your benefits, or need a replacement identification card, simply email your concierge at conciergehta@HealthTeamAdvantage.com, or call: PPO members call 888-965-1965 and HMO CSNP members call 833-324-3242 (TTY 711) October 1-March 31, 8 a.m. to 8 p.m. ET, seven days a week, or April 1-September 30, 8 a.m. to 8 p.m. ET, Monday through Friday.

HealthTeam Advantage Contact Information

Web Address
Visit HealthTeam Advantage at **HealthTeamAdvantage.com**.

Sales Information
Prospective members call toll-free 877-905-9216 for questions related to HealthTeam Advantage Medicare Advantage Plans October 1-March 31, 8 a.m. to 8 p.m. ET, seven days a week, or April 1-September 30, 8 a.m. to 8 p.m. ET, Monday through Friday.

TTY Users
TTY users call toll-free 711 for questions related to Medicare Advantage Plans.

Prescription Drug Benefit
Prospective members call toll-free 877-905-9216 for questions related to the HealthTeam Advantage Part D Prescription Drug Benefit.

Medicare Information
For more information about Medicare, call Medicare at 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, seven days a week or visit Medicare.gov.

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