Eon Health Enrollment Form

Eon Deluxe (HMO SNP)
Eon Silver (HMO SNP)
Eon Select (HMO)
Eon Gold (PPO SNP)
Eon Choice (PPO)

Need Help to Enroll?

- Contact your local sales agent to help you choose the best plan for you and complete this individual enrollment form, **or**

- Call Eon Health to help you enroll over the phone. Toll-free: 1-888-906-3889 (TTY users should call 711) We are open from October 1–March 31, seven days a week, 8:00am – 8:00pm EST and from April 1 – September 30, Monday through Friday, 8:00am – 8:00pm EST (you may leave a voicemail Saturday, Sunday and Federal Holidays)

You may also complete the enrollment form, sign and date it, and mail or fax the enrollment copy to:

Eon Health
Attn: Enrollment Department
3620 Enterprise Way
Miramar, FL 33025

Fax: 1-866-341-2265 (toll-free)

Instructions to complete the enrollment form for:

Eon Deluxe (HMO SNP)
Eon Silver (HMO SNP)
Eon Select (HMO)
Eon Gold (PPO SNP)
Eon Choice (PPO)

Please **PRINT NEATLY** on the entire form.

Please check which plan you want to enroll in then fill out the remainder of the form.

SECTION 1 – INFORMATION ABOUT YOU

This section tells us basic information about you such as your name, address, and phone number. All fields are required. Please print neatly.

SECTION 2 – MEDICARE INFORMATION

Please enter your Medicare information.

SECTION 3 M – MEDICAID INFORMATION

(Eon Deluxeonly)

Please enter your Medicaid identification number and social security number in the spaces provided.

-or –

SECTION 3 C – CHRONIC CONDITION INFORMATION

(Eon Silver or Eon Gold only)

Please read over each question carefully and answer 'Yes' to all that apply.

SECTION 4 – SELECT A PRIMARY CARE PHYSICIAN

Please write the name of the Primary Care Physician (PCP) that you want to choose in this section. The PCP must be in our network. You must give us as much information about the PCP as you can, such as the doctor's first and last name and if he/she belongs to a group or practice, if applicable. For example: (Doctor's Name): John Q. Smith, M.D. (Group/Practice Name): Greater Medical Associates.

PPO only: You are not required to select a PCP.

SECTION 5 – OTHER INSURANCE INFORMATION

It is very important that you tell us about any other health insurance or prescription drug coverage that you will have in addition to this Plan. This includes coverage that you may have on your own, through your spouse, or his/her employer, or through the state Medicaid program.

SECTION 6 – PLEASE READ AND ANSWER THESE QUESTIONS

1. Check 'YES' or 'NO' if you have a special kidney disease called End Stage Rena1 Disease (ESRD).
2. Check 'YES' or 'NO' if you or your spouse work.
3. Check 'YES' or 'NO' if you are a resident in a long-term care facility, such as a nursing home. (If YES, please provide the name, address and phone number of the long-term care facility.)
4. Check 'YES' or 'NO' if you would like to receive your information in Spanish or other formats.

SECTION 7 – PAYING YOUR PLAN PREMIUM and/or LATE ENROLLMENT PENALTY

If you are required to pay a premium and/or required to pay the Part D Late Enrollment Penalty, you will need to read this section carefully and select how you would like our Plan to collect this premium. Select only one: Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check OR get a bill monthly.

SECTION 8 –ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

This section of the form requires you to select an enrollment period that explains why you are entitled to enroll at this time. If you are enrolling during the annual election period, then you will select the first option, "I am making my annual enrollment period election (October 15 – December 7). If enrolling any time from December 8 – October 14, you will need to select one of the other options describing your specific circumstance, which will qualify you to enroll outside of the annual enrollment period.

STATEMENTS OF UNDERSTANDING

This portion of the form requires you to read several Statements of Understanding at the end of this form to be sure that you understand the terms of participating in our Plan. You must read and understand those statements.

AUTHORIZATION

Then sign your name and fill in today's date in this section. If you cannot sign and you have an authorized representative fill out this enrollment form on your behalf, then he/she must sign and date where indicated. Documentation of the authority to act on your behalf must be made available upon request by Eon Health or Medicare.

If anyone helped you fill out this enrollment form, such as a sales representative or community leader, then he/she must sign and date the form, and specify his/her relationship to you.

IMPORTANT REMINDERS

- You may include a **copy** of your MEDICARE HEALTH INSURANCE identification card.
- IF APPLICABLE, attach a copy of medical notes indicating that you do not need regular dialysis anymore or that you had a successful kidney transplant.
- IF APPLICABLE, attach a copy of the legal representative's proof of authorization by state law if someone signs on behalf of the applicant.

Enrollment Form

<< TRACKING # >>

Please contact Eon Health if you need information in another language or format Braille).

To Enroll in Eon Health, Please Provide the Following Information:

Please check which plan you want to enroll in:

For Medicare beneficiaries who have Medicare Part A and enrolled in Medicare Part B- Medicare Advantage Prescription Drug Plan (MAPD)

☐ Eon Select (HMO) $0 premium per month*
☐ Eon Choice (PPO) $25 premium per month*

For Medicare beneficiaries who also qualify for Medicaid or receive assistance from the State – Dual Eligible Special Needs Plan (D-SNP):

☐ Eon Deluxe (HMO SNP) $0 premium per month

For Medicare beneficiaries living with diabetes, cardiovascular disorders or chronic heart failure – Chronic Condition Special Needs Plan (C-SNP):

☐ Eon Silver (HMO SNP) $0 premium per month*
☐ Eon Gold (PPO SNP) $25 premium per month*

***** Your premium will be determined by the amount of Extra Help you may receive

SECTION 1 – INFORMATION ABOUT YOU (Please print neatly)

Last Name:	First Name:	Middle Initial:	☐Mr. ☐Mrs. ☐Ms.

Date of Birth: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Phone Number: (_ _ _ - _ _ _ - _ _ _ _) ☐ Home Phone ☐ Cell Phone ☐ Other Phone _____	SEX: M _____ F _____

Permanent Residence Address (Number, Street, Apartment) (P.O. Box is not allowed)			
City:	State:	Zip Code:	County:

Mailing Address (only if different from your Permanent Residence Address)			
City:	State:	Zip Code:	County:

SECTION 2 – MEDICARE INFORMATION (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.

SECTION 3 M– MEDICAID INFORMATION

NOTE: This section is to be completed only if applying for Eon Deluxe. To be eligible for this Plan, you must have Medicaid or be receiving assistance from the State.

Social Security Number _____ - _____ - _____
Please take out your Medicaid identification card to complete this section. Print your identification number as it appears on your Medicaid card.

Medicaid Number: _____

SECTION 3 C– CHRONIC CONDITION INFORMATION

NOTE: This section is to be completed only if applying for Eon Silver or Eon Gold. To be eligible for these Plans, you must have one of these conditions: Diabetes, Chronic Heart Failure (CHF), or Cardiovascular Disorder (CVD). Please answer the questions below.

☐Yes ☐No Have you ever been told by a doctor or clinic that you have diabetes (sugar)?

☐Yes ☐No Have you ever been told by a doctor or clinic that you have Congestive Heart Failure? (Such as fluid in the lungs or a weak heart)

☐Yes ☐No Have you ever been told by a doctor or clinic that you have Cardiac Arrhythmias? (An irregular heart beat or that your heart flutters or races)

☐Yes ☐No Have you ever been told by a doctor or clinic that you have Coronary Artery Disease? (Blocked arteries – had stents or heart bypass surgery – or a heart attack)

☐Yes ☐No Have you ever been told by a doctor or clinic that you have Peripheral Vascular Disease? (Poor blood flow to the legs; pain, burning or achiness in your legs when you walk, but goes away when you sit down)

☐Yes ☐No Have you ever been told by a doctor or clinic that you have Chronic Venous Thromboembolic Disorder? (Blood clots or are you taking Medicine for blood clots)?

SECTION 4– SELECT A PRIMARY CARE PHYSICIAN

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

Print the name and phone number of your chosen Primary Care Physician (PCP), group practice.

Doctor's Name: _____

Group/Practice Name: _____

Phone: (___ ___ ___) ___ ___ ___-___ ___ ___ ___

SECTION 5– OTHER INSURANCE INFORMATION

Some individuals may have other coverage including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you, on your own or through your spouse, have any health insurance or prescription drug coverage other than Medicare? ☐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:
_____	_____	_____

SECTION 6 – PLEASE READ AND ANSWER THESE 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. Do you or your spouse work? □Yes □No

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 :

Address:_____

Phone: (___ ___ ___) ___ ___ ___-___ ___ ___ ___

4. 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:

□ Spanish
□ Large Print
□ Other, please list the language _____
□ Audio Tape
□Braille

Please contact Eon Health at 1-844-895-8643 if you need information in an accessible format or language other than what is listed above. Our office hours are from October 1-March 31, seven days a week, 8:00am-8:00pm EST and from April 1-September 30, Monday through Friday, 8:00am-8:00pm EST. TTY users should call 711.

SECTION 7– PAYING YOUR PLAN PREMIUM and/or LATE ENROLLMENT PENALTY

Eon Select (HMO) and Eon Silver (HMO SNP): If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail with a check or money order or Electronic Funds Transfer (EFT) each month. 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 the RRB. DO NOT pay Eon Health the Part D-IRMAA.

Eon Choice (PPO), and Eon Gold (PPO SNP): You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail with a check or money order or Electronic Funds Transfer (EFT) each month.. You can also choose to pay your

premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

SECTION 7– PAYING YOUR PLAN PREMIUM and/or LATE ENROLLMENT PENALTY Continued

Eon Choice (PPO) and Eon Gold (PPO SNP): 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 Eon Health 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

☐ 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 ☐ Saving

☐ 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.)

Please Read This Important Information

If you currently have health coverage from an employer or union, joining an Eon Health MAPD plan could affect your employer or union health benefits. If you have health coverage from an employer or union, joining an Eon Health MAPD plan may change how your current coverage works. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

SECTION 8– ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

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 go 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 go 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 changes.

☐ 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.
□ I have a chronic condition that qualifies me for Eon Health's Chronic Condition Special Needs Plan.
If none of these statements applies to you or you're not sure, please contact Eon Health at 1-844-895-8643 (TTY users should call 711) to see if you are eligible to enroll. We are open from October 1 – March 31, seven days a week, 8:00am – 8:00pm EST and from April 1– September 30, Monday through Friday, 8:00am – 8:00pm EST (you may leave a voicemail Saturday, Sunday and Federal Holidays)
STATEMENTS OF UNDERSTANDING (Please read and sign below) **By completing this enrollment application, I agree to the following:**
1. Eon Health is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my 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. I understand that if I do not have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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. 2. Eon Health serves a specific service area. If I move out of the area that Eon Health 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 Eon Health, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Eon Health 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.

3. **Non-PPO plan only:** I understand that beginning on the date coverage begins, I must get all of my health care from Eon Health in-network, with the exception of emergency or urgently needed services or out-of-area dialysis services.

PPO plan only: I understand that beginning on the date coverage begins, using services in-network can cost less than using services out-of-network, with the exception of emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Eon Health provides reimbursement for all covered benefits, even if received out of network. Services authorized by and other services contained in my Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR EON HEALTH WILL PAY FOR THE SERVICES.

4. I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Eon Health he/she may be paid based on my enrollment in Eon Health.

5. **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 Eon Health 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.

AUTHORIZATION

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 including the Statements of Understanding.

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 by or by Medicare.

Your Signature: X_____ Date: __ __/__ __/__ __ __ __

AUTHORIZED REPRESENTATIVE: If you are the authorized representative, you must sign next to the "X" above, and provide the following information:

Name:_____ Relationship to Enrollee: _____

Address: _____

Phone: (___ ___ ___) ___ ___ ___-___ ___ ___ ___

FOR INTERNAL OFFICE USE ONLY	
To be filled out by staff member/agent/broker (if assisted in enrollment): Print Name: _____ Signature: _____ Agent/Broker Writing Number: _____ Referring Agent Number: _____ Date Application Received by Agent/Broker: Date: __ __/__ __/__ __ __ __ Proposed Effective Date: __ __/__ __/__ __ __ __ ICEP/IEP: □ OEP: □ AEP: □ SEP(type):_____ Not Eligible: □	Enrollment Use Only