OMB No. 0938-1378
Expires: 7/31/2023

SHARP HEALTH PLAN

Sharp Direct Advantage® Extra (dental not included)

EGWP 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)

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.

What happens next?

Mail or email your completed and signed form to:

Mail:
SDEHW
Attn: Open Enrollment
PO Box 231219
San Diego, CA 92193-121

Email:
Open Enrollment
Info@569trusts.org

How do I get help with this form?

Call 1-855-562-8853 (TTY/TDD: 711).

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Sharp Health Plan al 1-855-562-8853 (TTY/TDD: 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.

SECTION1: To enroll in Sharp Direct Advantage, please provide the following Information			
Employer or Union name: SDEHW			
Plan name: ☐ Sharp Direct Advantage Extra (Dental not included)			
First name:	Last name:	Middle initial:	☐ Mr. ☐ Ms. ☐ Mrs.
Birth date: MM/DD/YYYY / /	Sex: ☐ Male ☐ Female	Email address:	
Home phone number: ( )	Alternate phone number: ( )		
Permanent residence street address (Don't enter a PO Box):			
City:	County:	State:	ZIP code:
Mailing address, if different from your permanent address (PO Box allowed): Street address:			
City:	State:	ZIP code:	
Social security number:			
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.	Name (as it appears on your Medicare card): _____ Medicare number: _____ Is entitled to / Effective date HOSPITAL (Part A) _____ MEDICAL (Part B) _____		

IMPORTANT: Read and sign below

I must keep both Hospital (Part A) and Medical (Part B) to stay in Sharp Health Plan.

- By joining this Medicare Advantage Plan, I acknowledge that Sharp Health Plan 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 Sharp Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Sharp Health Plan. Benefits and services provided by Sharp Health Plan and contained in my Sharp Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Sharp Health Plan 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.

Signature: **x**	**Today's date:**

If you're the authorized representative, sign above and fill out these fields:

Name:	Address:
Phone number: ( )	Relationship to enrollee:

SECTION 2: Please read and answer these important questions

1. Are you the former employee of SDEWH? ☐ Yes ☐ No

If yes, employment end date (MM/DD/YY): _____

If no, name of retiree: _____

2. Please only answer this question if you are the former employee. Are you covering a spouse or dependent(s) under this employer plan? ☐ Yes ☐ No

If yes, name of spouse: _____

Name(s) of dependent(s):_____

Name(s) of dependent(s) employer:_____

Note: The spouse/dependent of the former employee will need to complete a separate application.

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

4. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Sharp 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 Coverage: _____

5. 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): _____

Please choose a Primary Care Physician (PCP):

PCP Name: _____ PCP Medical Group: _____

Are you a current patient? ☐ Yes ☐ No

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format:

☐ Spanish

☐ Accessible format (like Braille, audio or large print): _____

Please contact Sharp Health Plan at 1-855-562-8853 if you need information in an accessible format other than what's listed above. Our office hours are October 1 to March 31: 7 days per week 8 a.m. to 8 p.m. From April 1 to September 30: Monday through Friday, 8 a.m. to 8 p.m., and on weekends and holidays, your call will be handled by our voicemail system. A Customer Care Representative will return your phone call the next business day. TTY/TDD users should call 711.

Attestation of Eligibility for an Enrollment Period

Please read the following statement carefully and check the box if the statement applies to you.

By checking the following box 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 a former employee or spouse/domestic partner/dependent of a former employee of _SDEHW_ and I am not actively employed by _SDEHW_.

If this statement does not apply to you or you're not sure, please email **Info@569trusts.org** to see if you are eligible to enroll.

Exhibit 1a: Information to include on or with Enrollment Mechanism – Attestation of Eligibility for an Enrollment Period, continued

☐ 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.

If none of these statements applies to you or you're not sure, please email **Info@569trusts.org**, to see if you are eligible to enroll.

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.