bright HEALTH Enroll a Client

1-888-325-1747 Log out

ENROLLMENT

Instructions

Welcome to Bright Health Plan's Online Enrollment Tool for Medicare Advantage. This form is intended to be used exclusively by Bright Health licensed agents. If you have any questions, please contact our Broker Service Unit (BSU) at brokers@brighthealthplan.com or 1-888-325-1747.

Take Note

- Please do not log off before completing the enrollment - this form does not support save and return.
- A confirmation will be available after submission - please save for your records.
- This tool can be used three ways:

1. Electronic enrollment with the member. Submit, save, and be done!
2. Enter a paper application and either upload or fax the chase copy once submitted, and get an instant confirmation. Please note, The submission of this form without the timely submittal of the matching paper enrollment application can delay the enrollment of the Medicare beneficiary.
3. For approved Telephonic Sales Agents. If you are not sure if you qualify, please contact the BSU.

Enrollment Checklist

Select type of application*

Electronic enrollment with member present

☐ I have a completed Scope of Appointment form*

☐ I have reviewed the following key plan information with the Member - (1) plan effective date, (2) benefits & riders (if applicable), (3) premium & payment information (if applicable), (4) network information (primary care doctor, specialists, and network), (5) pharmacy information (costs, benefits, and locations)*

☐ I have explained eligibility requirements, election periods, and disenrollment timeframes with Member*

☐ I reviewed and left a copy with the member of the following material - (1) Enrollment Booklet, (2) Multi-language insert, (3) Non-Discrimination Notice insert*

Agent Info

NPN ID*

12345

Agent Name*

admin@brighthealthplan.com

Phone number*

5551231234

Please use 10 digits, no spaces or dashes

Where did this application originate?*

Appointment

Application Receipt Date*

October 12 2018

Proposed Effective Date*

January 01 2019

Plan State*

Alabama

Plan*

Select

Beneficiary Contact Information

Title

Select

First Name* **Middle Initial** **Last Name***

Birth Date*

January 01 1954

Gender*

Select

Primary phone **Alt phone** **Email address**

XXXXXXXXXX XXXXXXXXXX example@domain.com

Please use 10 digits, no spaces or dashes Please use 10 digits, no spaces or dashes

By giving my email address, I agree to receive email about my benefits, health programs, and other plan services.

Permanent residence

(P.O. Box is not allowed)

Street address*

Street address 2

City* **State*** **Zip Code*** **County**

Select 12345

Is your mailing address different than the address of your primary residence?*

No

Emergency Contact

Emergency contact name

Full Name

Emergency contact relationship

e.g., Spouse

Emergency contact phone number

XXXXXXXXXX

Please use 10 digits, no spaces or dashes

Medicare Information

Enter your medicare number*

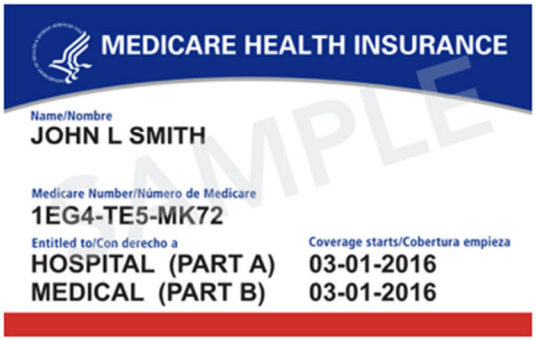
e.g., 000000000A

Medicare Part A effective date*

January | 01 | 2019

Medicare Part B effective date*

January | 01 | 2019



*Each example below shows what is required when the answer is YES. If NO is selected, the fields will not show.

Do you have End-Stage Renal Disease (ESRD)?*

Yes

If yes, and 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.

844-679-2031 TTY: 711
Monday-Friday, 8am-8pm CT

Additional Coverage Information

Do you have additional coverage (employer, TRICARE, VA benefits, federal employee benefits, etc)?*

Yes

What does it cover?

- Medical*
- Prescription drugs*

Coverage Name* | **Member ID** | **Group ID**

123456 | 123456

State Medicaid Coverage Details

Are you enrolled in your state's Medicaid program?*

Yes

Medicaid Number*

123456

Employment Information

Do you or your spouse work?*

Yes

Long Term Care Facility

Do you live in a long term care facility like a nursing home?*

Yes

Facility Name*

Street address*

City* **State*** **Zip Code*** **Phone***

Select

12345

XXXXXXXXXX

Please use 10 digits, no spaces or dashes

*The language drop-downs make what is available in each state

Preferred Language

Please select one of the options below if you would prefer us to send you information in a language other than English or in another format.

English

Other formats

Select

Please contact Bright Health at 844-679-2031 TTY: 711 if you need information in another language or format than what is listed above. Our office hours are Monday-Friday, 8am-8pm CT.

Primary Care Physician

Primary Care Physician First Name **Primary Care Physician Last Name**

Provider ID

12345

Click here to look up a Primary Care Physician ID in a new tab.

Payment

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 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 Bright Health the Part D-IRMAA.

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail 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 RRB. DO NOT pay Bright 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.

How would you like to pay your premium?

Select

Eligibility

Typically, you may enroll in a Medicare Advantage plan only during the open 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. If none of these apply to you, you may need to wait until the Open Enrollment Period, which runs October 15 to December 7.

Eligibility Options

- [x] I am enrolling during the annual election period*
- [ ] 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 was recently released from incarceration.*
- [ ] I recently returned to the United States after living permanently outside the U.S.*
- [ ] I recently obtained lawful presence status in the U.S.*
- [ ] I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid).*
- [ ] I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help).*
- [ ] I have both Medicare and Medicaid or my state helps pay for my Medicare premium or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.*
- [ ] I am moving into, live in, or recently moved out of a long-term care facility (like a nursing home).*
- [ ] I recently left a PACE program.*
- [ ] I recently, involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).*
- [ ] I am leaving employer or union coverage.*
- [ ] I belong to a pharmacy assistance program provided by my state.*
- [ ] My current plan provider 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.*

☐ 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 affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements where applied to me, but I was unable to make my enrollment.*

If none of these statements apply or you still have questions, give us a call. We're happy to help (844-679-2031 TTY: 711, Monday-Friday, 8am-8pm CT).

Legal Text

By completing this enrollment application, I agree to the following:

Bright Health 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.

Bright Health serves a specific service area. If I move out of the area that Bright 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 Bright 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 Bright 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.

Services authorized by Bright Health and other services contained in my Bright Health Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BRIGHT HEALTH WILL PAY FOR THE SERVICES.**

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

[If you are requesting enrollment in an HMO plan the following statement applies: I understand that beginning on the date Bright Health coverage begins, I must get all of my health care from Bright Health participating providers, except for emergency or urgently needed services or out-of-area dialysis services.]

[If you are requesting enrollment in an HMO-POS plan the following statement applies: I understand that beginning on the date Bright Health coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Bright Health may reimburse you for certain services when provided by an out of network provider.]

[If you are requesting enrollment in an PPO plan the following statement applies: I understand that beginning on the date Bright Health coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Bright Health provides reimbursement for all covered benefits, even if I get services out of network.]

Release of Information: By joining this Medicare health plan, I acknowledge that Bright Health will release my information to other parties for treatment, payment and health care operations, including without limitation to Medicare, other plans, providers, and Bright Health's Care Partner. I also acknowledge that Bright 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 form the plan.

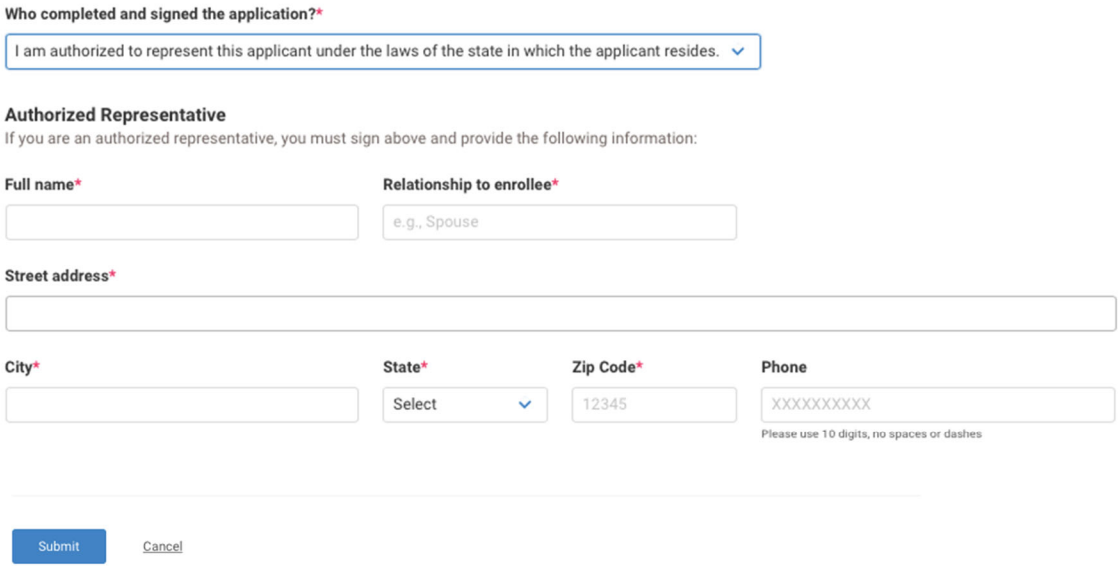
I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature 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.

☐ I agree to the legal disclaimer and am ready to enroll*

Date*

October ⌄ 12 ⌄ 2018 ⌄

*If the member does not have a power of attorney, they will select I am the applicant and there is no additional info needed.



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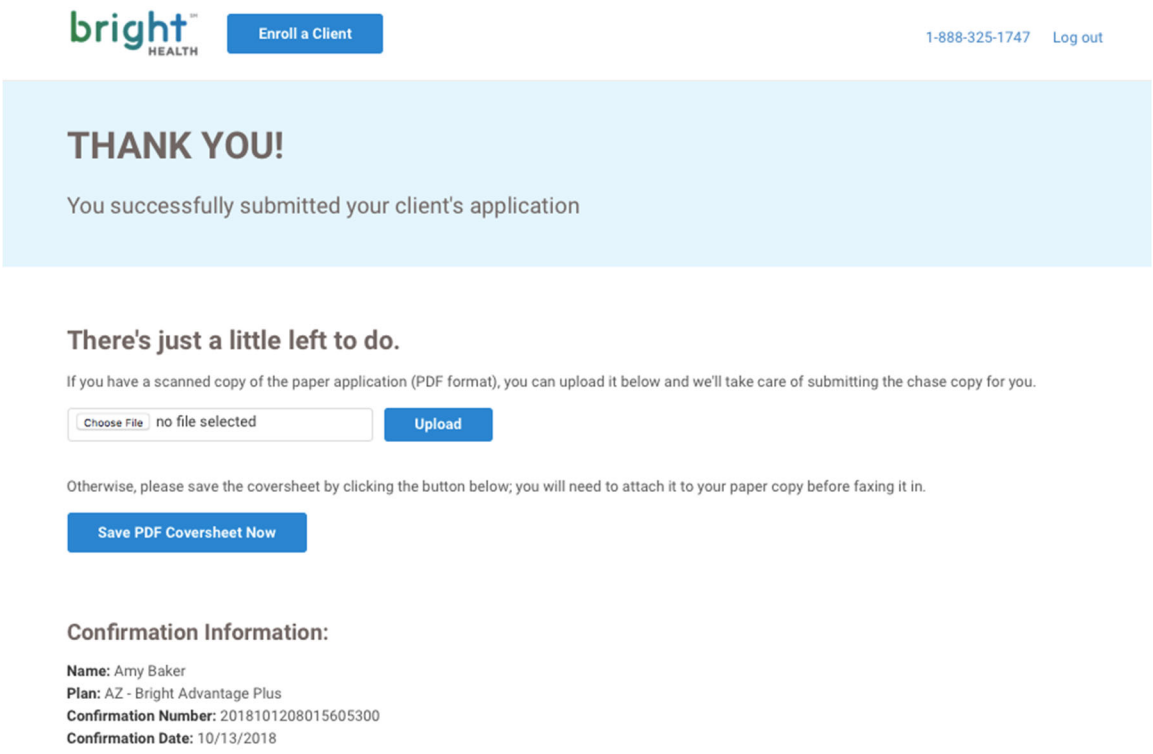

*Electronic and Telephonic apps will have an option to save a copy of the app details for their records.