2025 Enrollment Form

Simpra Advantage
Alabama's Healthplan

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)

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 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 the 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 monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Fax your completed and signed form to:
(205) 994-7530

Or Mail to: Simpra Advantage, PO Box 23607, Tampa, FL 33623-3607. Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Simpra Advantage at 1-844-637-4770. TTY/TDD users can call 1-833-312-0044.

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

En español: Llame a Simpra Advantage al 1-844-637-4770 (TTY/TDD 1-833-312-0044) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

SECTION 1: To enroll, all fields in this section are required (unless marked optional)

Please check which plan you want to enroll in:

☐ Simpra Advantage Nursing Home Plan (PPO I-SNP) - $40.00 per month **($0 for full dual eligibles with Extra Help)**
☐ Simpra Advantage Dual Care (PPO D-SNP) - $40.00 per month **($0 for full dual eligibles with Extra Help)**
☐ Simpra Advantage Assist (PPO I-SNP) - $86.00 per month

If you get Extra Help from Medicare, your monthly plan premium will be lower than what it would be if you didn't get Extra Help from Medicare. **Depending on your level of Extra Help, your premium may be as low as $0.**

Applicant Information: ☐ Male ☐ Female

☐ Mr. ☐ Mrs. ☐ Ms. Birth Date (MM/DD/YYYY): (_____/_____/_____)

First Name_____Last Name_____M.I.____

Applicant's Medicare information:

Medicare Number (MBI)_____

Are you enrolled in your State Medicaid program?

☐ Yes
☐ No

IF YES, what is your Medicaid number? _____

Please list your County of residence: _____

Answer these important questions:

1. Will you have other prescription drug coverage in addition to Simpra Advantage?

   ☐ Yes
   ☐ No

   IF YES, please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other drug coverage _____

   ID for this coverage _____

   Group # for this coverage _____

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

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SECTION 1 (continued): To enroll, all fields in this section are required (unless marked optional)

I-SNP ONLY (If you are enrolling in the I-SNP, please fill out this question)

2. Are you a resident of or expect to be a resident of a long-term care facility (LTC) or an assisted living facility (ALF) in the Simpra Advantage network for more than 90 days?

   ☐ Yes
   ☐ No

   IF YES, please fill out the facility information below:

   Name of Facility _____

   Street Address _____

   City_____State_____Zip_____

   Phone Number of Facility _____

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SECTION 1 (continued): To enroll, all fields in this section are required (unless marked optional)

IMPORTANT: Read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Simpra Advantage.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Simpra 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.
- I understand that Simpra Advantage does not cover me while I'm out of the country, except for limited coverage near the U.S. border.
- I understand that I can be enrolled in only one Medicare Advantage plan at a time and that enrollment in this plan will automatically end my enrollment in another Medicare Advantage plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Simpra Advantage coverage begins, I must get all of my medical and prescription drug benefits from Simpra Advantage. Benefits and services provided by Simpra Advantage and contained in my Simpra Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Simpra Advantage will pay for benefits or services that are not covered.
- 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 my signature or the signature of my Authorized Representative (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 below), 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 of applicant or Authorized Representative	Date
_____	_____

SECTION 1 (continued): To enroll, all fields in this section are required (unless marked optional)

Applicant Contact Information:

Permanent Residence Address (P.O. Box not allowed):

Street_____

City_____ State_____ Zip_____

Email* (optional) _____

** By providing your email address, you are opting in to receive electronic communications at this email address, when available. If you do not wish to receive electronic communications at this email address, check this box:* ☐ *Opt out*

Preferred Phone (_____) _____ Is this your ☐Cell phone** or ☐Home phone

*** By providing your cell phone number, you are opting in to receive electronic communications via SMS/text message, when available. If you do not wish to receive electronic communications via SMS/text message at this cell number, check this box:* ☐ *Opt out*

Secondary Phone (_____) _____

Please list a second phone number of a family member or friend who can be contacted if we are not able to reach you at your preferred phone number above. We will not text them. We will not share Protected Health Information with this person without your approval.

Name_____

Relationship to Enrollee_____

Mailing Address, if different from permanent address (P.O. Box allowed):

Attn Name_____

Street_____

City_____State_____Zip _____

Authorized Representative Contact Information (as applicable):

If you're the Authorized Representative, you must sign the previous page and fill out these fields:

First Name_____Last Name _____

Street_____

City_____State_____Zip_____

Relationship to Enrollee_____

Email* (optional)_____

** By providing your email address, you are opting in to receive electronic communications at this email address, when available. If you do not wish to receive electronic communications at this email address, check this box:* ☐ *Opt out*

Preferred Phone (_____) _____ Is this your ☐Cell phone** or ☐Home phone

*** By providing your cell phone number, you are opting in to receive electronic communications via SMS/text message, when available. If you do not wish to receive electronic communications via SMS/text message at this cell number, check this box:* ☐ *Opt out*

Secondary Phone (_____) _____ Is this your ☐Cell phone** or ☐Home phone

*** By providing your cell phone number, you are opting in to receive electronic communications via SMS/text message, when available. If you do not wish to receive electronic communications via SMS/text message at this cell number, check this box:* ☐ *Opt out*

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SECTION 2: All fields in this section are optional. Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

1. Do you work?

   ☐ Yes
   ☐ No

   Does your spouse work?

   ☐ Yes
   ☐ No

2. List your Primary Care Physician (PCP), clinic, or health center:

   _____

   Is this your current provider? ☐ Yes ☐ No

3. **Please tell us the language you would like to speak** when talking with Simpra representatives. Select one choice below.

   ☐ English
   ☐ Spanish
   ☐ Other (Non-English): _____
   ☐ I choose not to answer.

4. We send required documents to members in English.
   Please tell us if you need to receive documents in another language. Select one choice below.

   ☐ English
   ☐ Spanish
   ☐ Other (Non-English): _____
   ☐ I choose not to answer.

5. **Please tell us if you need documents in an *accessible format***.

   ☐ Audio File
   ☐ Large Print
   ☐ Braille
   ☐ I do not need accessible formats

Please contact Simpra Advantage at 1-844-637-4770 (TTY/TDD users can call 1-833-312-0044) if you need information in an accessible format or language other than what is listed above. Our office hours are 8:00 am to 8:00 pm local time.

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6. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer.**

7. What is your race? Select all that apply.

- ☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White

- ☐ **I choose not to answer.**

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SECTION 2 (continued): All fields are optional. Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Paying Your Plan Premium

For plans with a premium, you can pay your monthly plan premium (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.**

- ☐ Yes, I'd like my premium to be taken out of my Social Security benefit.
- ☐ Yes, I'd like my premium to be taken out of my Railroad Retirement Board (RRB) benefit.
- ☐ No, none of the above. I would like a direct bill.

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 Simpra 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) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 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.

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SECTION 3: This is a required section. See instructions below.

Attestation of Eligibility

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.

- ☐ **AEP:** I am enrolling during the Annual Enrollment Period (October 15 – December 7).
- ☐ **IEP:** I am new to Medicare.
- ☐ **OEP:** I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (January 1 – March 31).
- ☐ **OEPI:** I am in an institution like a nursing home and would like to make a change or I recently moved out of an institution.
- ☐ **ICEP:** I already have Hospital (Part A) and recently signed up for Medical (Part B). I want to join a Medicare Advantage Plan.
- ☐ **IEP2:** I am turning 65 and not new to Medicare.
- ☐ **OTHER ENROLLMENT PERIOD:** _____
- ☐ **SEP: Special Election Period (choose one reason for enrollment below, if this category applies to you)**
  - ☐ **RESIDENCE:** I recently moved outside my service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.
  - ☐ **CHANGE 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) _____.
  - ☐ **DISASTER:** I was affected by an emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA) or a government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
  - ☐ **CHANGE MEDICAID:** I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
  - ☐ **CHANGE EXTRA HELP:** I recently had a change in 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) on (insert date) _____.
  - ☐ **LTC/MOVE IN OR OUT:** 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) _____.
  - ☐ **PACE:** I recently left a Program of All-inclusive Care for the Elderly (PACE®) on (insert date) _____.
  - ☐ **LOST RX COVERAGE:** I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
  - ☐ **LOST EMPLOYER/UNION COVERAGE:** I am leaving employer or union coverage. Employer/Union coverage started on (insert date) _____ and coverage ends on (insert date) _____.

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☐ **STATE RX ASSISTANCE:** I belong to a pharmacy assistance program provided by my state.

☐ **RETURN TO U.S.:** I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.

☐ **LAWFUL PRESENCE:** I recently obtained status in the United States. I got this status on (insert date) _____.

☐ **PLAN CONTRACT END:** My plan is ending its contract with Medicare or Medicare is ending its contract with my plan.

☐ **LOST SNP ELIGIBILITY:** 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) _____.

☐ **RELEASED FROM INCARCERATION:** I was recently released from incarceration. I was released on (insert date) _____.

☐ **LOW PERFORMING PLAN:** My current plan has been determined to be a Consistently Low Performing Plan and I would like to change plans.

☐ **OTHER SEP:** _____

If none of these statements applies to you or you're not sure, please contact Simpra Advantage at 1-844-637-4770 (TTY/TDD users can call 1-833-312-0044) to see if you are eligible to enroll.

We are open 8am to 8pm local time, 7 days a week from October 1st – March 31st, 5 days a week from April 1st – September 30th. We are closed on the following holidays: Memorial Day, Independence Day, Labor Day, Thanksgiving and Christmas.

OFFICE USE ONLY. Please DO NOT complete unless authorized.

Agent First and Last Name: _____

Agent Phone Number: _____ **Agent Email:** _____

AL License: _____ **NPN:** _____

Application received date: _____ **Coverage effective date:** _____

Signature: _____ **Date:** _____