# 2027-2029 Enrollment Form

SimpraAdvantage
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 8 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.

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 0938-1378. 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.

**IMPORTANT: Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.**

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

**Select the plan you want to join:**

- ☐ Simpra Advantage Nursing Home Plan (PPO I-SNP) - $13.70 per month **($0 with Extra Help)**
- ☐ Simpra Advantage Dual Care (PPO D-SNP) - $13.70 per month **($0 with Extra Help)**
- ☐ Simpra Advantage Assist (PPO I-SNP) - $90.00 per month

*Extra Help is a federal program that helps individuals with limited income pay for Part D prescription drugs. Eligibility is determined based on income and asset limits set by the Social Security Administration.*

**Applicant Information:**

First Name_____Last Name_____M.I._____
Birth Date (_____/_____/_____) (MM/DD/YYYY) Sex: ☐ Male ☐ Female
Applicant's Medicare Number (MBI)_____
Are you enrolled in your State Medicaid program? ☐ Yes ☐ No
*IF YES, what is your Medicaid number?* _____

**Applicant Permanent Residence Address (Do not enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):**

Street _____
City_____ State_____Zip_____
County of Residence_____

**Applicant Mailing Address, if different from permanent address (PO Box allowed):**

Attn Name _____
Street _____
City_____State_____ Zip _____

**Applicant Contact Information:**

Email Address* (optional)_____

** By providing your email address, you are opting in to receive electronic communications from Simpra Advantage at this email address, when available. If you do not wish to receive electronic communications from Simpra Advantage 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 from Simpra Advantage via SMS/text message, when available. Message frequency may vary. Message and data rates may apply. Your mobile information will never be shared for marketing purposes with affiliates nor with third parties under any circumstances. You may reply STOP to our texts at any time to unsubscribe. You may reply HELP to our texts at any time to get help. See the Simpra Advantage Privacy Policy at https://simpra.com/privacy-policy-2/. If you do not wish to receive electronic communications from Simpra Advantage via SMS/text message at this cell phone number, check this box: ☐ Opt out*

**Will you have other prescription drug coverage (like VA, TRICARE) in addition to Simpra Advantage?**
☐ Yes ☐ No

**IF YES, please provide this information:** Name of other drug coverage _____

Member number_____ Group number_____

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

**If you are enrolling in an I-SNP plan (Nursing Home Plan or Assist Plan), do you reside or expect to reside in an institutional care facility such as a long-term care facility (LTC) or an assisted living facility in the Simpra Advantage network for more than 90 days?** ☐ **Yes** ☐ **No**

**IF YES, provide the Facility information:**

Facility Name _____

Street, City, State, Zip _____

Phone _____

**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 (MA) 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 I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA 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 my Simpra Advantage plan. 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 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 of Applicant or Authorized Representative Today's Date

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

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

Name_____

Street_____

City_____ State_____ Zip_____

Relationship to Enrollee _____

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

*** By providing your cell phone number, you are opting in to receive electronic communications from Simpra Advantage via SMS/text message, when available. Message frequency may vary. Message and data rates may apply. Your mobile information will never be shared for marketing purposes with affiliates nor with third parties under any circumstances. You may reply STOP to our texts at any time to unsubscribe. You may reply HELP to our texts at any time to get help. See the Simpra Advantage Privacy Policy at https://simpra.com/privacy-policy-2/. If you do not wish to receive electronic communications from Simpra Advantage via SMS/text message at this cell phone number, check this box: ☐ Opt out*

Email Address* (optional) _____

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

## 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.**

**Select one if you want us to send you information in an accessible format.**

☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Please contact Simpra Advantage Member Services at 1-844-637-4770 (for accommodations, TTY/TDD users can call 1-833-312-0044) if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m. local time, 7 days a week from October 1st to March 31st, and Monday through Friday from April 1st to September 30th. Member Services is closed on Memorial Day, Juneteenth, Independence Day, Labor Day, Thanksgiving, and Christmas.

**Do you work?** ☐ Yes ☐ No

**Does your spouse work?** ☐ Yes ☐ No

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

_____

**Paying Your Plan Premiums**

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.**

**I would like my premium to be taken out of my (choose one):**

☐ Social Security Benefit ☐ Railroad Retirement (RRB) Benefit ☐ Neither. 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.

## IMPORTANT – Complete only if you are helping an enrollee fill out this form.

**Complete this section if you're an individual (i.e., agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form**.

**Name:** _____

**Signature:** _____

**Relationship to enrollee** (agent, broker, SHIP counselor, family member, or other third party)**:**

_____

**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.

OFFICE USE ONLY

**COMPLETE ONLY IF YOU ARE AN AGENT/BROKER OR A PLAN REP.**

**THIS PAGE MUST BE SUBMITTED WITH THE APPLICATION.**

**Agent/Broker National Producer Number (NPN):** _____

**Application Received Date:** _____

**Coverage Effective Date:** _____

**Enrollment Eligibility:**

☐ **AEP** ☐ **IEP** ☐ **OEP** ☐ **OEPI** ☐ **ICEP** ☐ **IEP2**

☐ **SPECIAL ENROLLMENT PERIOD (See list below)** _____

☐ **OTHER** _____

## SPECIAL ENROLLMENT PERIODS

| | |
|---|---|
| CHANGE EXTRA HELP | LOST PRESCRIPTION COVERAGE |
| CHANGE MEDICAID | LOST SPECIAL NEEDS PLAN ELIGIBILITY |
| CHANGE PLAN | LOW PERFORMING PLAN |
| CHANGE RESIDENCE | PACE |
| DISASTER | PLAN CONTRACT END |
| LAWFUL PRESENCE OBTAINED | RELEASED FROM INCARCERATION |
| LONG TERM CARE MOVE IN OR OUT | RETURN TO U.S. |
| LOST EMPLOYER OR UNION COVERAGE | STATE PRESCRIPTION ASSISTANCE |

Simpra Advantage is a PPO I-SNP and PPO D-SNP with a Medicare contract. Enrollment in Simpra Advantage depends on contract renewal. Simpra Advantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Based on a Model of Care review, Simpra Advantage has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through 2029. We do not offer every plan available in your area. Currently, our contracted sales agents represent eight organizations which offer 104 products in your area. Please contact Medicare.gov, 1-800-MEDICARE (24 hours a day, 7 days a week, except some federal holidays) to get information on all of your options. For accommodations for persons with special needs, call 1-844-637-4770 (TTY/TDD 1-833-312-0044) 8 a.m. – 8 p.m. local time, 7 days a week from October 1st to March 31st and Monday to Friday from April 1st to September 30th. Member Services is closed Memorial Day, Juneteenth, Independence Day, Labor Day, Thanksgiving, and Christmas.

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