Medicare Advantage Plan Individual Enrollment Request Form

Zing HEALTH™

SECTION 1 – TO ENROLL IN ZING HEALTH, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Select the plan you want to join:

INDIANA

- ☐ **H4624-011 Zing Select Diabetes & Heart IN (HMO C-SNP) $0 per month**
- ☐ **H4624-025 Zing ESRD Select IN (HMO C-SNP) $0 per month**
- ☐ **H6876-005 Zing Open Choice Diabetes & Heart IN (PPO C-SNP) $0 per month**
- ☐ **H4624-024 Zing Select Diabetes & Heart Complete IN (HMO C-SNP) $42.30 per month**
- ☐ **H6876-006 Zing Choice Diabetes & Heart Complete IN (PPO C-SNP) $42.30 per month**
- ☐ **H4624-003 Zing Select Care IN (HMO) $0 per month**
- ☐ **H4624-026 Zing Elite Select IN (HMO) $0 per month**
- ☐ **H6876-004 Zing Open Choice IN (PPO) $0 per month**

FIRST Name: LAST Name: [Optional: Middle Initial]:

Birth Date: Sex: Phone Number: Cell Number:

(__ __ / __ __ / __ __ __ __) ☐ Male (_____) _____ (_____) _____
(M M / D D / Y Y Y Y) ☐ Female

Permanent Residence street address (Don't enter a P.O. Box):

Street Address: City:

County: State: ZIP Code:

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

Street Address: City: State: ZIP Code:

Your Medicare information:

Name (as it appears on your Medicare card): **Medicare Number:**

__ __ __ __ - __ __ __ - __ __ __ __

Hospital (Part A) Effective Date: **Medical (Part B) Effective Date:**

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Answer these important questions:

1 **Will you have other prescription drug coverage (like VA, TRICARE, State Pharmaceutical Assistance Program (SPAP)) in addition to Zing Health?** ☐ Yes ☐ No

Name of other coverage: Member number for this coverage: Group number for this coverage:

2 **Do you have any chronic conditions, such as a Cardiovascular Disorders, Chronic Heart Failure, Diabetes, and/or End Stage Renal Disease (ESRD)?** ☐ Yes ☐ No

3 **Are you enrolled in your State Medicaid program?** ☐ Yes ☐ No

If yes, please provide your Medicaid number: _____

STOP IMPORTANT: Read and sign below: STOP

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Zing Health Plan.
- By joining this Medicare Advantage Plan, I acknowledge that Zing Health 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 Zing Health coverage begins, I must get all of my medical and prescription drug benefits from Zing health. Benefits and services provided by Zing Health and contained in my Zing Health "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Zing Health 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: _____ **Today's Date:** __ __ / __ __ / __ __ __ __

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

Name: Address:

Phone Number: Relationship to Enrollee:

( )

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Agent Name: _____ Agent ID #:_____ Event#/Lead Source: _____

Plan ID #:_____ Plan Name:_____ Effective Date of Coverage: ___/___/_____

Election Type: ☐ ICEP/IEP ☐ AEP ☐ SEP (Type):_____ Date (if applicable): ___/___/_____

SECTION 2 – ALL FIELDS ON THIS PAGE ARE OPTIONAL

Answering these questions is your choice.
You cannot be denied coverage because you don't fill them out.

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**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer**

Select if you want us to send you information in a language other than English. ☐ Spanish

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

☐ Braille ☐ Large print ☐ Audio CD

Please contact Zing Health at 1-866-946-4458 if you need information in an accessible format other than what is listed above. Our office hours are 8:00 a.m. to 8:00 p.m. Monday through Friday (7 days a week from October 1 through March 31). TTY users can call 711.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

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

PCP Name:

PCP #:

PCP Address:

City:

State:

PCP Phone Number:
( )

I want to get the following materials via email. Select one or more.

☐ Evidence of Coverage ☐ Summary of Benefits ☐ Abridged Formulary

Email Address: _____

PAYING YOUR PLAN PREMIUMS

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.**

If you have to pay a Part D-Income Related 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 Zing Health 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) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.