



Agent & Office Use Only		
Date Received:	Date Submitted:	Effective Date:
Agent Name:	National Producer Number:	Agent Phone Number:

Individual Enrollment Form

Please contact Vibra Health Plan if you need information in another language or format (Braille).

To Enroll in Vibra Health Plan, Please Provide the Following Information:

MA-PD only (includes hospital, medical & Part D)

- \$0.00 per month - Vibra Health Plan **Essential** Coverage PPO
- \$49.50 per month - Vibra Health Plan **Enhanced** Coverage PPO

MA-PD and dental (includes hospital, medical & Part D and dental)

- \$33.30 per month - Vibra Health Plan **Essential** Coverage PPO (\$0.00) and **Essential Dental** (\$33.30)
- \$77.50 per month - Vibra Health Plan **Enhanced** Coverage PPO (\$49.50) and **Enhanced Dental** (\$28.00)

Fill out your personal information

LAST Name:	FIRST Name:	Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date: MM / DD / YYYY	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ()	Alternate Phone Number: ()
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	County:	State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Street Address):			
City:	State:	ZIP Code:	
Email address (optional):			

Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card - **OR** -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

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



SAMPLE ONLY

Name: _____
 Medicare Claim Number _____ Sex _____
 _____ - _____ - _____

Is Entitled To	Effective Date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

Paying Your Plan Premium

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 your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, “Electronic Funds Transfer (EFT)”, credit card 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 Vibra Health Plan 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 offices 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.

If you don’t select a payment option, you will get a bill each month.

Please select a premium payment option:

Get a monthly bill

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

NOTE: Other payment options offered are: **Credit Card payments and Electronic funds transfer (EFT).** To enroll in these options, **after your enrollment application has been approved**, please contact Vibra Health Plan at 1-844-388-8268 (TTY users should call 711). We are open seven (7) days a week 8 A.M to 8 P.M. You can also visit Vibra Health Plan’s member portal to sign-up. Further details will follow in your **Member Welcome Kit**. We will send you a paper bill for your monthly premiums until the Credit Card or EFT option is effective.

Please read and answer these important questions:

Yes No

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

If 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.

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.</p> <p>Will you have other <u>prescription</u> drug coverage in addition to Vibra Health Plan? If “yes”, please list your other coverage and your identification (ID) number(s) for this coverage: Name of other coverage: _____</p> <p>ID # for this coverage: _____ Group # for this coverage: _____</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>3. Are you a resident in a long-term care facility, such as a nursing home? If “yes,” please provide the following information: Name of Institution: _____ Address: _____ Phone Number of Institution: _____</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>4. Are you enrolled in your State Medicaid program? If “yes”, please provide your Medicaid number: _____</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>5. Do you or your spouse work?</p>

Please choose the name of a Primary Care Physician (PCP), clinic or health center: *(Optional)*

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

- Language (call for availability)
 Large Print
 Audio Tape

Please contact Vibra Health Plan at 1-844-388-8268 if you need information in another format or language than what is listed above. Our office hours are seven (7) days a week 8 A.M to 8 P.M. TTY users should call 711.



Please Read This Important Information

If you currently have health coverage from an employer or union, joining Vibra Health Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Vibra Health Plan. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn’t any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below

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

Vibra Health Plan 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.

Vibra Health Plan serves a specific service area. If I move out of the area that Vibra Health Plan 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 Vibra Health Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Vibra Health Plan 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.

I understand that beginning on the date Vibra Health Plan 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, Vibra Health Plan provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Vibra Health Plan and other services contained in my Vibra Health Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR VIBRA HEALTH PLAN WILL PAY FOR THE SERVICES.**

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

Release of Information: By joining this Medicare health plan, I acknowledge that Vibra Health Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Vibra Health Plan will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which will 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 provided false information on this form, I will be disenrolled from the plan.

I understand that my signature (or 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 for 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.

Signature:		Today's Date:	
If you are the authorized representative, you must sign above and provide the following information:			
Name:		Address:	
Relationship to enrollee:		Phone Number:	
Office Use Only:			
Name of staff member/agent/broker (if assisted in enrollment):			
Plan ID#:			
Effective Date of Coverage:			
ICEP/IEP:	AEP:	SEP (type):	Not Eligible:

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.

- I am new to Medicare.
- 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 moved on MM / DD / YYYY (insert date).
- I recently was released from incarceration. I was released on MM / DD / YYYY (insert date).
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on MM / DD / YYYY (insert date).
- I recently obtained lawful presence status in the United States. I got this status on MM / DD / YYYY (insert date).
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on MM / DD / YYYY (insert date).
- 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 MM / DD / YYYY (insert date).
- I recently left a PACE program on MM / DD / YYYY (insert date).
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on MM / DD / YYYY (insert date).
- I am leaving employer or union coverage on MM / DD / YYYY (insert date).
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my 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 disenrolled from the SNP on MM / DD / YYYY (insert date).

If none of these statements applies to you or you're not sure, please contact Vibra Health Plan at 1-844-388-8268 (TTY users should call 711) to see if you are eligible to enroll. We are open seven (7) days a week 8 A.M to 8 P.M.



Vibra Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-388-8268 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-388-8268 (TTY: 711)。