VIBRA™ Health Plan

To enroll in a Vibra Health Plan, please provide the following information:

	Monthly Premiums	
	Plan Premium	**Select ONLY ONE:**
Essential PPO	$0.00	☐
Enhanced PPO	$60.00	☐

Fill out your personal information:

LAST Name:

FIRST Name:

Middle Initial:

Birth Date:	Sex:	Home Phone Number:	Alternate Phone Number:
MM / DD / YYYY	☐ M ☐ F	### - ### - ####	### - ### - ####

Permanent Residence Street Address (PO Box is not allowed):

City:	County (enter county designated for local tax):	State:	ZIP Code:

Mailing Address *(only if different from your Permanent Residence Street Address)*:

City:	State:	ZIP Code:

Email address:
(optional)

Please choose the name of a Primary Care Physician (PCP), clinic or health center: *(Optional)*
Name of Physician (first and last): _____
Name of Practice or clinic: _____
Address: _____
Phone Number: _____

Please provide your Medicare health insurance card information:

Please take out your red, white and blue Medicare card to complete this section.

- Please fill out this information as it appears on your Medicare card.

– OR –

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number:

_____

Is Entitled To	Effective Date
HOSPITAL (Part A)	M M / D D / Y Y Y Y
MEDICAL (Part B)	M M / D D / Y Y Y Y

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

Paying Your Plan Premium

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), or 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 (IRMAA), 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 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**.

I get monthly benefits from: ☐ **Social Security** ☐ **RRB**

(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.)

☐ **Credit Card and Electronic Funds Transfer (EFT) payments** Please do NOT provide any credit card or EFT information with this enrollment application. We will send you a paper bill for your monthly premiums until the Credit Card or EFT option is effective**.**

Please select how you would like to enroll in the Credit Card or EFT options (SELECT ONE):

☐ **Phone** – *After your enrollment application has been approved*, please call 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.

☐ **Vibra Member Portal** – *After your enrollment application has been approved*, please visit **www.vibrahealthplan.com** to access our member portal to sign-up. Further details will follow in your **Member Welcome Kit.**

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.
☐ Yes ☐ No	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. Will you have other prescription 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: _____ ID # for this coverage: _____ Group # for this coverage: _____
☐ Yes ☐ No	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: _____
☐ Yes ☐ No	4. Are you enrolled in your State Medicaid program? **If "yes," please provide your Medicaid number:** _____
☐ Yes ☐ No	5. Do you or your spouse work?

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:

☐ Audio Tape ☐ Spanish ☐ Large Print

Please contact Vibra Health Plan at 1-844-388-8268 (TTY 711) if you need information in an accessible format or language other than what is listed above. Our office hours are as follows: October 1 through March 31, 8 a.m. to 8 p.m., seven (7) days a week; hours for April 1 through September 30, 8 a.m. to 8 p.m., Monday through Friday, with secure messaging on Saturdays, Sundays, and federal holidays.

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:** MM / DD / YYYY

If you are the authorized representative, you must sign above and provide the following information:

Name:	**Phone Number:** ### - ### - ####
Address:	**Relationship to enrollee:**

Agent & Office Use Only:

Agent Name:

Date Received: MM / DD / YYYY	Date Submitted: MM / DD / YYYY	Effective Date: MM / DD / YYYY

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

Agent ID #:	Agent Phone Number: ### - ### - ####

Enrollment Type:

☐ ICEP/IEP ☐ SEP (type): _____

☐ AEP ☐ Not Eligible: _____

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.

- ☐ 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 moved on (mm/dd/yyyyy) _____.
- ☐ I recently was released from incarceration. I was released on (mm/dd/yyyyy) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (mm/dd/yyyyy) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (mm/dd/yyyyy) _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (mm/dd/yyyy) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in level of Extra Help, or lost Extra Help) on (mm/dd/yyyyy) _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) 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 (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (mm/dd/yyyyy) _____.
- ☐ I recently left a PACE program on (mm/dd/yyyy) _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (mm/dd/yyyy) _____.
- ☐ I am leaving employer or union coverage on (mm/dd/yyyy) _____.
- ☐ 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 plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (mm/dd/yyyy) _____.
- ☐ 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) _____.
- ☐ I was affected by a weather-related emergency (as declared by the Federal Emergency Management Agency [FEMA]). One of the other statements here applied to me but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you are 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.