HealthPartners®

2021

INDIVIDUAL HEALTHPARTNERS® FREEDOM ENROLLMENT FORM — WISCONSIN

This is the enrollment application for your HealthPartners® Freedom plan options. Follow the steps outlined and review the important notes below before filling out your form. You can also apply online or over the phone. See back page for more information.

Step 1: Select your plan.

- **HealthPartners® Freedom Basic WI (Cost)**
- **HealthPartners® Freedom Vital WI (Cost)**
- **HealthPartners® Freedom Balance WI (Cost)**

Step 2: Fill out the remainder of the questions, including signing and dating the form. Forms that are not signed or completed may be returned, which may delay your enrollment. **Mail the completed form to HealthPartners in the enclosed self-addressed envelope.** Each individual must complete a separate enrollment form.

Important Information

- You must be enrolled in the Federal Medicare Program for Part A and Part B, or Part B only, to join a HealthPartners® Freedom plan. You have to keep Medicare Parts A and B or B only while you are a member of our plan. If you only have Medicare Part B, you will only be covered for Medicare Part B services.
- Generally, you must live in this plan's service area. If you are a current member and live outside the service area , contact Medicare Sales at the numbers on the back. For more information, see the enclosed Summary of Benefits.
- You do not need more than one Medicare Supplement, Medicare Cost or Medicare Select policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement, Medicare Cost or Medicare Select policy.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement or Medicare Cost insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). See the "Wisconsin Guide to Health Insurance for People with Medicare" which you received with this application.
- This document is available in alternative formats and languages. Please contact Medicare Sales at the numbers on the back of this form for more information.

SECTION ONE: Personal Information

LAST NAME | FIRST NAME | M.I.

BIRTH DATE / / | SEX: ❑ F ❑ M | EMAIL ADDRESS* (optional)

TELEPHONE Home ( ) - | Alternate ( ) -

Is this a cell phone? ❑ YES ❑ NO | Is this a cell phone? ❑ YES ❑ NO

PERMANENT HOME ADDRESS
(P.O. Box is not allowed) | APT #

CITY | STATE | ZIP | COUNTY

IN CARE OF NAME (If applicable)

IN CARE OF MAILING ADDRESS
(If different from permanent home address) | APT #

CITY | STATE | ZIP | COUNTY

*By providing your email address, you agree that HealthPartners may send you emails.

SECTION TWO: Plan Selection

Choose ONE plan option

❑ **Freedom Basic WI** – $33.60/month*
❑ **Freedom Vital WI** – $39.70/month*
❑ **Freedom Balance WI** – $82.60/month*

❑ **Optional Comprehensive Dental Benefit –** Check this box if you'd like to add this benefit for $43.10/month.*
This benefit is not available with Freedom Basic WI. You can disenroll from this benefit at any time.

❑ **Optional Benefit Rider –** Please check this box if you'd like to add this benefit rider for $42.00/month.*
This benefit rider is only available with Freedom Balance WI. See the Summary of Benefits for more information. You can disenroll from this benefit rider at any time.

You must continue to pay your Medicare Part B premium.

HealthPartners must receive your completed, signed and dated enrollment form no later than the last working day of the month before you want coverage to begin. **I would like coverage to start:** (Month)_____ , **2021**.
We will accommodate your requested effective date as best we can while still following Medicare guidelines.

SECTION THREE: Billing Selection

Once you're a Freedom plan member, you can sign up to automatically receive and pay your bills online.

Choose ONE payment option (If you don't select an option, you will get a paper bill each month.):

❑ Paper billing (You'll receive a monthly paper bill unless you sign up for online billing.)

❑ I am a HealthPartners member and want my current auto-pay method and bank information applied to this plan.

❑ Electronic funds transfer (EFT) from your bank account each month. Your payment will be taken on the first business day of the month. Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: _____ Bank account number: _____

Account type: ❑ Checking ❑ Savings

❑ Automatic deduction from your monthly Social Security (SS) or Railroad Retirement Board (RRB) benefit check

I get monthly benefits from: ❑ Social Security ❑ RRB

The SS/RRB deduction may take two or more months to begin. In most cases, if SS/RRB accepts your request for automatic deduction, the first deduction from your SS/RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If your request isn't approved, we will send you a paper bill. You cannot select this option if your total monthly premium is $300 or more. If you enroll in the dental benefit or benefit rider, it cannot be billed through SS/RRB deduction. You will receive a separate invoice.

SECTION FOUR: Medicare Information

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

- 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)	_____
MEDICAL (Part B)	_____

SECTION FIVE: Please answer the following questions

❑ YES ❑ NO **1. Do you have both Medicare and Medicaid or does the state help pay your Medicare premiums?**
If YES, what is your Medicaid number? _____

❑ YES ❑ NO **2. Do you have end-stage renal disease (ESRD)?**
If you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

❑ YES ❑ NO **3. Do you or your spouse work?**

❑ YES ❑ NO **4. Do you have health coverage through you or your spouse's current or former employer?**
If YES, please provide the following information:
Employer Name_____ Employer Address_____
Policy Holder Name_____ Policy Number _____

❑ YES ❑ NO **5. Are you currently a HealthPartners member?**
If YES, please give your identification number (to avoid duplication): _____

STOP! Please read page 5 before signing below.

Release of Information: By joining this Medicare health plan, I acknowledge that HealthPartners will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on the form, I will be disenrolled from the plan.

I understand that my signature (or the 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 of this application. It also means I acknowledge that I have received the Notice to Applicant Regarding Replacement of Medicare Supplement, Medicare Cost, Medicare Select, Medicare Advantage or Existing Accident and Sickness Insurance (found on page 5 of this application) and the Wisconsin Guide to Health Insurance for People with Medicare. 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 (enrollee or authorized representative) **Today's date**

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

Name _____ Address _____

Phone number (_____) _____ -_____Relationship to enrollee _____

Agent Use Only:

Agent name (please print): _____ Agent signature: _____

Agent code: _____ Agent telephone: _____ Agent's receipt date:_____ /_____ /_____

SECTION SIX: Authorization and Acknowledgement

PLEASE READ AND SIGN ON PAGE 4

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

HealthPartners® Freedom is a Medicare Cost plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B, or B only. I can only be in one Medicare health plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I know I may disenroll from this plan at any time by sending a written request to HealthPartners or by calling **800-MEDICARE,** available 24 hours a day, seven days a week. TTY users should call **877-486-2048**.

HealthPartners® Freedom serves a specific service area. (See the Summary of Benefits for more details.) If I move out of the area that the Freedom 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 the Freedom plan, I have the right to appeal plan decisions about payment and services if I disagree. I will read the plan's Evidence of Coverage (EOC) to know which rules I must follow to get coverage with this Medicare Cost plan.

I understand that beginning on the date HealthPartners® Freedom coverage starts, in order for the plan to fully cover my medical services (except for emergency or urgently-needed services), all of my health care must be provided or arranged by HealthPartners. If I obtain services not provided or arranged by the plan, I will be responsible for all Medicare deductibles and coinsurance, as well as any additional charges as prescribed by the Medicare program. I may also be liable for charges not covered by Medicare.

Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico. Services authorized by HealthPartners and other services contained in my HealthPartners® Freedom (Cost) Evidence of Coverage document will be covered.

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

Notice to Applicant Regarding Replacement of Medicare Supplement, Medicare Cost, Medicare Select, Medicare Advantage or Existing Accident and Sickness Insurance

According to your application, you intend to terminate existing Medicare Supplement, Medicare Cost, Medicare Select or Medicare Advantage insurance and replace it with a policy to be issued by HealthPartners.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If you are in a Medicare Supplement or Medicare Select plan, you should terminate your present Medicare Supplement or Medicare Select coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

HealthPartners Medicare Cost plans do not contain any waiting periods for pre-existing conditions. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the Application. After the Application has been completed, and before you sign it, review it carefully to be certain that all information has been properly recorded. Do not cancel your present policy until you have received your new policy and are sure you want to keep it.

Contact us

By phone
For questions call Medicare Sales at **952-883-5601** or **800-247-7015**.
TTY users should call **711**.

By email
Email questions to **medicaresales@healthpartners.com**.

On the Web
Find more information or print off additional copies of this application at **healthpartners.com/medicare**.

Enroll

Return paper applications in the enclosed postage-paid envelope to:
HealthPartners Riverview Membership Accounting
MS 21103R
P.O. Box 9463
Minneapolis, MN 55440

Or fax them to **952-853-8746**.

By phone
To enroll over the phone, call **952-883-7788** or **877-240-8311**.

On the Web
Apply online at **healthpartners.com/medicare.**

Hours of Operation

From **Oct. 1 through Dec. 7,** we take calls from 8 a.m. to 6 p.m. CT, **Monday through Saturday.**
From **Dec. 8 through Sept. 30,** call us 8 a.m. to 6 p.m. CT, **Monday through Friday** to speak with a representative. On Federal holidays and days we're closed, you can leave a message and we'll get back to you within one business day.

8170 33rd Ave. S.
PO Box 1309
Minneapolis, MN 55440-1309

This policy will be jointly issued by HealthPartners Inc. and HealthPartners Insurance Company.

FREEDOM ENROLLMENT FORM – WI
H2462_000302_C APPROVED 08/28/2020