Doctor-Built. Patient-Focused.

Enrollment Application

Enroll in a Reliance Medicare Advantage Plan
By completing this Enrollment Application

Via phone by calling 1-833-653-2041 (TTY: 711)
Monday - Sunday, 8:00 am to 8:00 pm (EST)
Online at www.RelianceMedicareAdvantage.org

Enrollment form Instructions

- Make sure to fill out the entire enrollment application to avoid any delays
- Please write clearly in blue or black ink
- Have your red, white, and blue Medicare ID card on hand
- Review the application to make sure each section is completed and you have chosen the right plan
- Save a copy of the enrollment application for your records

You may have your Reliance Medicare Advantage Navigator deliver your enrollment application to Reliance Medicare Advantage, or you may send your completed application to the address below:

Reliance Medicare Advantage
Enrollment Department
23900 Orchard Lake Road Suite 210
Farmington Hills, MI 48366
Fax: 248-715-5415

Did you:

☐ Fill out all the required fields
☐ Check the appropriate box for the plan you want to join
☐ Choose a Primary Care Provider (PCP)
☐ Sign and date your application

OMB No. 0938-1378
Expires: 7/31/2023

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:
- ☐ H9861 Plan 001 Principle Plan $0.00 per month
- ☐ H9861 Plan 002 Cardinal Plan $40.00 per month
- ☐ H9861 Plan 003 Dual Care Plus Plan $0.00 per month[1]

FIRST name:	LAST name:	Optional: Middle Initial:
Birth date: (MM/DD/YYYY) (/ /)	Sex: ☐ Male ☐ Female	Phone number: ( )

Permanent Residence street address (Don't enter a PO Box):

City:	Optional: County:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):
Street address:
City: State: ZIP Code:

Your Medicare information:

Medicare Number: __ __ __ __ - __ __ __ __ - __ __ __ __
Effective Dates: Medicare Part A ____________________ Medicare Part B ____________________

Answer these important questions:

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

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

Do you have Medicaid: ☐ Yes ☐ No Medicaid Number: ____________________

YOU MUST HAVE MEDICARE AND MEDICAID COVERAGE TO ENROLL IN DUAL CARE PLUS

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Reliance Medicare Advantage.
- By joining this Medicare Advantage Plan, I acknowledge that Reliance Medicare 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 on next page).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Reliance Medicare Advantage coverage begins, I must get all of my medical and prescription drug benefits from Reliance Medicare Advantage. Benefits and services provided by Reliance Medicare Advantage and contained in my Reliance Medicare Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Reliance Medicare Advantage will pay for benefits or services that are not covered.
- 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:
    - This person is authorized under State law to complete this enrollment
    - Documentation of this authority is available upon request by Medicare

Signature: **Today's date:**

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

Name:	Address:
Phone number:	Relationship to enrollee:

OMB No. 0938-1378
Expires: 7/31/2023

Section 2 – All fields on this page 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 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 Reliance Medicare Advantage at 855-959-5855 if you need information in an accessible format other than what's listed above. Our office hours are: October 1 - March 31, seven days a week from 8:00 a.m. - 8:00 p.m. Eastern, April 1 - September 30, Monday - Friday 8:00 a.m. - 8:00 p.m. Eastern. 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:

I want to get the following materials via email. Select one or more.
☐ Spanish ☐ Braille ☐ Audio Large Print

E-mail 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 or "Electronic Funds Transfer (EFT)" 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 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 Reliance Medicare Advantage 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) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 22.60 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.

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-NEW. 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.

[1]Amount shown does not include Medicare Part B premium, which you must continue to pay if not otherwise paid for under Medicaid or by another third party. Beneficiaries who qualify for Extra Help may pay a lower monthly plan premium. For more information, contact Reliance.

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 (insert date) ______________________________.

☐ I recently was released from incarceration. I was released on (insert date)______________________________.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) ______________________________.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) ____________.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) ______________________________.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) ______________________________.

☐ 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 (insert date) ______________________________.

☐ I recently left a PACE program on (insert date) ______________________________.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) ______________________________.

☐ I am leaving my employer or union coverage on (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 plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date)______________________________.

☐ 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 (insert date) ______________________________.

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact Reliance Medicare Advantage at 855-959-5855 (TTY users should call 711) to see if you are eligible to enroll. We are open October 1 - March 31, seven days a week from 8:00 a.m. - 8:00 p.m. Eastern, April 1- September 30, Monday-Friday from 8:00 a.m. - 8:00 p.m. Eastern.