HealthPartners® Freedom Group Plan Enrollment Instructions
For Group Enrollees with Medical coverage only
Each individual must complete a separate enrollment form

You are eligible to join HealthPartners® Freedom if:

- You are enrolled in the Federal Medicare Program for Part A (hospital coverage) AND Part B (medical coverage) or you are enrolled in Part B only. If you have Medicare Part B only, you will only have coverage for Medicare Part B services. You will not have coverage for hospital, skilled nursing facilities, and related services covered by Medicare Part A; and
- You live in the plan’s service area. This eligibility condition does not apply if you are already a commercial member of HealthPartners. However, if you move to a different out-of-area address after the initial enrollment, CMS requires HealthPartners to disenroll you from the plan; and
- You DO NOT have End Stage Renal Disease (ESRD). ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive. If you have ESRD, you cannot enroll in this plan unless you are already a commercial member of HealthPartners and developed ESRD while you were a non-Medicare member; and
- You have NOT elected hospice care (special services for the terminally ill) under Medicare.

HealthPartners is a health plan with a Medicare contract.

Important information:

- After we receive your enrollment form, we will send your member identification card and a letter stating when your coverage begins. HealthPartners must receive your completed, signed and dated enrollment form by the last working day of the month before you want coverage to begin. Coverage always begins on the first day of a future month.

To enroll, please follow these steps:

1) Fill out ALL of the enrollment form except shaded areas. Incomplete or incorrect enrollment forms may delay the effective date of your coverage. Use a ball-point pen and print firmly to ensure clear carbon copies.

2) Provide a PHOTOCOPY of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board with this enrollment form. Or you may fill out the information in Section Two exactly as it appears on your Medicare card.

3) Carefully read, sign and date the enrollment form.

4) Send your completed enrollment form to:
   HealthPartners Sales
   P.O. Box 1309
   Minneapolis, MN 55440-1309
   Fax: 952-853-8718
# HealthPartners® Freedom Group Plan Enrollment Form

## SECTION ONE: Personal information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M. I.</th>
<th>Social Security Number</th>
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<thead>
<tr>
<th>Date of Birth (MM/DD/YY)</th>
<th>Home Phone (area code)</th>
<th>Work Phone (area code)</th>
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<tr>
<th>Permanent Home Address</th>
<th>Apt. No.</th>
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<table>
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<tr>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
<th>County</th>
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<tr>
<th>Mailing Address (if different from permanent home address)</th>
<th>Apt. No.</th>
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- Male □ | Female □

## SECTION TWO: Medicare & Plan Selection information

Please choose one medical plan option:

- □ Plan 1: $218.30
- □ Plan 2: $137.30

Please provide a PHOTOCOPY of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board with this enrollment form. **Or you may fill out the information as it appears on your Medicare card.**

### For employer use

Name of Employer ____________________________________________
Group no. ________________________
Effective date ________________________
Is applicant the retiree? □ Yes □ No □ Actively Employed □ Retired
Retirement Date ________________________
Name of retiree if not applicant ________________________

### HealthPartners Use Only

Eff. Date:
MR#
Ctct #
Received:
SECTION THREE: Please answer the following questions

1. Do you have End Stage Renal Disease (ESRD)? ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive. If your answer is YES, you cannot enroll in this plan unless you do not need regular dialysis any more, or have had a successful kidney transplant. Please attach a note from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. Have you already elected hospice care (special services for the terminally ill) under Medicare? If YES, you cannot enroll in this plan.

3. Do you or your spouse have health insurance other than Medicare, such as private insurance, worker’s compensation, or VA benefit? If YES, include insurance name and address; policyholder name and number.

Your answers to the following questions will not affect your eligibility for enrollment in this plan:

4. Are you now or have you ever been a HealthPartners member? If YES, please include your identification number (to avoid duplication).

5. Do you have Medicare prescription drug (Part D) coverage or other drug coverage that is at least as good as standard Medicare prescription drug coverage (credible coverage) since you became eligible to join a Medicare drug plan?

If not, you may have to pay a penalty. HealthPartners may ask you to provide evidence that some or all of your previous prescription drug coverage was at least as good as Medicare drug coverage.

For questions regarding medical and dental plan options, call 952-883-5601 or 1-800-247-7015, Monday - Friday, 8 a.m. to 6 p.m. For questions about Medicare Part D prescription drug benefits, including copayments, deductibles and network pharmacies, call 952-883-5601 or 1-800-247-7015, 7 days a week, 8 a.m. to 8 p.m. TTY users should call 952-883-6060 or 1-800-443-0156.
SECTION FOUR: Authorization and acknowledgement

Generally, I can be a member of only one Medicare medical plan and one Medicare Prescription Drug (Part D) Program at a time. By enrolling in this plan, I will automatically be disenrolled from any other Medicare medical plan and Medicare Prescription Drug (Part D) Program, including a Medicare Health Plan (Medicare Advantage and Medicare Cost plans) of which I am currently a member.

I must keep my Medicare Part A, Part B insurance by paying the premiums.

“Effective date of coverage” is when I should begin using the plan’s services. The plan will still send me final approval of my enrollment in the plan. I understand that I should not disenroll from any Medicare supplement plan, or Medicare Advantage plan until I get that approval from the plan.

Beginning on the date HealthPartners® Freedom Group plan coverage begins, I must get all of my health care from HealthPartners® Freedom Group plan, with the exception of emergency or urgently needed services. In addition to being covered in the United States, emergency and urgently needed services are covered in certain hospitals in Mexico and Canada. If I do not receive care from HealthPartners, I will be liable for all applicable Medicare fees and copays. HealthPartners will not cover these services.

There may be times when I may not be able to disenroll from the HealthPartners® Freedom Group plan. I may disenroll by sending a written request to the plan or by calling 1-800-MEDICARE, (1-800-633-4227) 24 hours a day/7 days a week (TTY: 1-877-486-2048 for the hearing and speech impaired). Until the effective date of disenrollment, I must keep getting health care from the HealthPartners® Freedom Group plan doctors.

As a member of the plan, I have the right to ask about the plan’s decision about payment or services if I disagree.

I must tell HealthPartners before I move out of the service area. I understand that if I move permanently out of the service area, Medicare requires HealthPartners to disenroll me.

It is my job to tell HealthPartners about other prescription drug coverage I may have. If I intentionally misrepresent this information, Medicare requires the plan to disenroll me if this plan has a Medicare Prescription Drug (Part D) Program.

Since I currently have health coverage from my employer or union group, enrolling in other coverage could affect my employer or union health benefits.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.

I understand that my signature on this application means that I have read and understand the contents of this application. Note: To find out more about the rules and procedures you must follow in order to receive coverage, please read the HealthPartners® Freedom Group plan Evidence of Coverage. (This will be sent to you automatically once you are enrolled or upon request.)

Enrollment generally begins the first day of the month after HealthPartners receives your completed form and verifies your eligibility.

Your Signature* ________________________________ Date ________________

* If the individual cannot sign, a court-appointed legal guardian or person with Power of Attorney, if authorized by state law; or another person who is authorized by state law, must sign the following line. Attach a copy of proof of Legal Guardian, Power of Attorney, or proof of authorization by state law.

Signature __________________________________________ Date ______________________

If anyone helped the applicant fill out this form, she or he must sign below:

Please sign here: ________________________________ Relationship: _________________ Date: ________________