SHARP HEALTH PLAN

2017-2018 Sharp Advantage® Employer Group Enrollment Form

Office Use Only:
Name of staff member/agent/broker (if assisted in enrollment):
_____ CA License #: _____
Plan ID #: 802
ICEP/IEP: ____ AEP: _____ SEP (type): X Not Eligible: _____

This plan is open to all Medicare-eligible City of San Diego retirees, sponsored by MEA. MEA membership is not required to join this plan. Please contact Sharp Health Plan at 1-855-820-2112 (TTY 711) if you need information in another language or format.

To enroll in Sharp Advantage please provide the following information:

Effective Date of Coverage: MM/DD/YY (/ 01 /)

Employer or Union Name: **City of San Diego Medicare Retirees**

I would like to enroll in the following plan.
☑ Sharp Advantage MEA ($179 per month) (81004)

This plan is for Medicare enrolled retirees only. If you are not eligible for Medicare, please contact MEA for the Non-Medicare Enrollment Form at 1-888-217-9175 or visit www.SDMEA.org to download the enrollment form.

Last Name:	First Name:	Middle Initial:

Birth Date: MM/DD/YY (/ /)	Sex ☐ M ☐ F	Primary Phone Number: ( )	Cell 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 Address):

City:	State:	ZIP Code:

Email Address:	☐ Yes, I'd like to receive health plan news and information via email.

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) _____

Mail to: Sharp Health Plan | Medicare Dept.
8520 Tech Way, Suite 201 | San Diego, CA 92123

Please read and answer these important questions:

1. Are you the City of San Diego retiree? ☐ **Yes** ☐ **No**

If yes, retirement date (MM/DD/YY): _____ If no, name of retiree: _____

2. Are you covering a Medicare-eligible spouse or dependent(s) under this employer or Union plan?

☐ **Yes** ☐ **No** If yes, name of spouse: _____

Name(s) of dependent(s): _____

3. Do you or your spouse work? ☐ **Yes** ☐ **No**

4. Do you have End-Stage Renal Disease (ESRD)? ☐ **Yes** ☐ **No**

If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **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.

5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Sharp Advantage? ☐ **Yes** ☐ **No**

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____ ID # for this coverage: _____

6. Are you a resident in a long-term care facility, such as a nursing home? ☐ **Yes** ☐ **No**

If "yes," please provide the following information:

Name of institution: _____ Phone number of institution: _____

Address of institution (number and street): _____

7. Please choose a Primary Care Physician (PCP): Existing patient: ☐ **Yes** ☐ **No**

PCP Name: _____ PCP Medical Group: _____

Need to find a doctor? Visit sharpmedicareadvantage.com/findadoctor to use our online search tool.

8. Please check the box if you would prefer us to send you information in a language other than English or in another format: ☐ **Spanish** ☐ **Other** _____

9. What is your current health coverage type and insurance company?

_____

Please contact Sharp Advantage at 1-855-820-2112 if you need information in another format or language than what is listed above (TTY users should call 711). Our office hours are from 8 a.m. to 6 p.m., Monday to Friday.

Sharp Advantage is offered by Sharp Health Plan. Sharp Advantage is an HMO plan with a Medicare contract. Enrollment in Sharp Advantage depends on contract renewal. You must continue to pay your Part B premium. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change as of January 1 of each year.

Mail to: Sharp Health Plan | Medicare Dept.
8520 Tech Way, Suite 201 | San Diego, CA 92123

Exhibit 1a: Information to include on or with Enrollment Mechanism – Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the City of San Diego Medicare Retirees' open enrollment period from the first Monday in June through June 30 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 a retiree or spouse/domestic partner/dependent of a retiree of the City of San Diego enrolling during open enrollment (June 5 - June 30, 2017).
- ☐ 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 (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 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 (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 (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 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 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) _____.

If none of these statements apply to you or you're not sure, please contact Sharp Advantage at 1-855-820-2112 (TTY users should call 711) to see if you are eligible to enroll. We are open Monday through Friday, 8 a.m. to 6 p.m.

Please Read and Sign Below
By completing this enrollment application, I agree to the following: Sharp Advantage 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 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. It is my responsibility to inform the plan 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 if an enrollment period is available (Example: Annual Enrollment Period), or under certain special circumstances. Sharp Advantage serves a specific service area. If I move out of the area that Sharp Advantage 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 Sharp Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Sharp Advantage 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 Sharp Advantage coverage begins, I must get all of my health care from Sharp Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Sharp Advantage and other services contained in my Sharp Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR SHARP ADVANTAGE 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 Sharp Advantage, he/she may be paid based on my enrollment in Sharp Advantage. **Release of Information:** By joining this Medicare health plan, I acknowledge that Sharp Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Sharp Advantage will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which 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 provide false information on this 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. 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: **x**	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:	
Name:	Relationship to Enrollee:
Address:	Phone Number: ( )

Non-discrimination notice

Sharp 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. Sharp Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Jamie Ryan, Director of Operations at (858) 499-8275.

If you believe that Sharp Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Sharp Health Plan
Appeal/Grievance Department
Attn: Jamie Ryan, Director of Operations
8520 Tech Way, Suite 201
San Diego, CA 92123-1450
Toll-free: 1-855-820-2112
TTY: 711
Fax: (858) 636-2256

You can file a grievance in person or by mail or fax. If you need help filing a grievance, Sharp Health Plan's Director of Operations is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html.**

Multi-Language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-820-2112. Someone who speaks English/ Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-820-2112. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-855-820-2112。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-855-820-2112。我們講中文的人員將樂意為您提供幫助。這 是一項免費服。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-820-2112. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-820-2112. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-855-820-2112 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-820-2112. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-820-2112 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-855-820-2112. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 2112-820-855-1. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-855-820-2112 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-855-820-2112. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-820-2112. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-855-820-2112. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer
1-855-820-2112. Ta usługa jest bezpłatna.

Japanese:当社の健康 健康保険と□品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通□をご用命になるには、1-855-820-2112にお電話ください。日本語を話す人

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-820-2112 (հեռատիպ 711):

Persian:توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با. تماس بگیرید.1-855-820-2112 (TTY 711)

Punjabi: **ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।** 1-855-820-2112 (TTY 711) **'ਤੇ ਕਾਲ ਕਰੋ।**

Mon-Khmer, Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-820-2112 (TTY 711)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-820-2112 (TTY 711).

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-820-2112 (TTY 711).