

Who can use this form?

People with Medicare who want to join a Medicare Advantage (MA) Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15 – December 7 each year (for coverage starting January 1)
- Within three months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit *Medicare.gov* to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare ID number (the number on your red, white and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items Section 1. The items in Section 2 are optional- you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall Annual Enrollment Period (October 15 – December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
St. Luke's Health Plan
Attn: MA Enrollment
PO Box 1739
Boise, ID 83702

Email: slplanenrollment@slhealthplan.org

Or enroll online at medicare.stlukeshealthplan.org. Once they process your request to join, they'll contact you.

How do I get help with this form?

Call St. Luke's Health Plan at **833-840-1216 (TTY: 711)**, or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, seven days a week.

En español: Llame St. Luke's Health Plan al **833-840-1216 (TTY: 711)** o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., Social Security checks) may be considered your permanent residence address.

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 0938-1378. 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. **IMPORTANT** Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Section 1: All questions in this section are mandatory (unless marked optional)

Confirm the plan you are applying for by checking the box below:

- ☐ **St. Luke's Advantage Rx 01 (HMO) – H3012-001**
\$77/month. Available in Ada, Canyon & Elmore counties only
- ☐ **St. Luke's Advantage Rx 02 (HMO) – H3012-002**
\$142/month. Available in Blaine & Valley counties only
- ☐ **St. Luke's Advantage Rx 03 (HMO) – H3012-003**
\$107/month. Available in Jerome & Twin Falls counties only

Your Information

First Name:		Last Name:		M.I.
Birth Date:	Sex: ☐ Male ☐ Female	Telephone:	Alt. Telephone (optional):	
Email Address (optional):			County (optional):	
Medicare Beneficiary Identifier (MBI): <i>The number on your red, white and blue Medicare card</i>		(Optional) Part A Effective Date: Part B Effective Date:		
Permanent residence street address. (Don't enter a P.O. Box. Note: For individuals experiencing homelessness, a P.O. Box may be considered your permanent residence address):				
Street Address:		City:	State:	Zip Code:
Mailing address , if different from your permanent address (P.O. Box allowed):				
Address:		City:	State:	Zip Code:

Answer These Important Questions

Will you have other prescription drug coverage (such as VA or Tricare) in addition to St. Luke's Health Plan, Inc.?			☐ Yes ☐ No
If you selected Yes:	☐ VA	☐ Tricare	☐ Other (specify):
Member ID for this coverage:		Coverage Start Date:	
Group ID for this coverage:		Coverage End Date:	

Section 2: All questions in this section are optional

You are not required to answer the following questions, and you cannot be denied coverage if you choose not to answer. If you have questions, please call 833-840-1214 (TTY: 711), October 1 to March 31, seven days a week from 8 a.m. to 8 p.m. and April 1 to September 30, Monday through Friday, from 8 a.m. to 8 p.m.

Alternate Formats

Select one of the options below if you want information in an accessible format:

☐

Braille

☐

Large Print

☐

Audio CD

☐

Data CD

Current Employment

Do you work?

☐

Yes

☐

No

Does your spouse work?

☐

Yes

☐

No

Your Eligibility for Enrollment

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period (AEP) 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 these 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. If none of these statements apply to you or you're not sure, you can call **833-840-1216 (TTY: 711)** to see if you are eligible to enroll. We are available October 1 to March 31, seven days a week, from 8 a.m. to 8 p.m. and April 1 to September 30, Monday to Friday from 8 a.m. to 8 p.m.

☐

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) January 1 through March 31.

☐

I recently moved outside of the service area for my current plan or I recently moved and this plan is a new available option for me. I moved or will move on:

☐

I am enrolling during the Annual Enrollment Period (AEP), which runs October 15 – December 7.

☐

I recently was released from incarceration. I was released on:

☐

I recently returned to the United States after living permanently outside the U.S. I moved or will move back to the U.S. on:

☐

I recently obtained lawful presence status in the United States. I got or will get this status on:

☐

I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid). This change happened on:

☐	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). This change happened on:
☐	I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).
☐	I am in a Medicare Advantage Plan and have had Medicare for less than three months. I want to make 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 acute care facility). I moved/will move into/out of the facility on:
☐	I recently left a PACE (Programs of All-Inclusive Care for the Elderly) program. I left the PACE program on:
☐	I recently involuntarily lost other my creditable prescription drug coverage (coverage that's as good as Medicare prescription drug coverage). I lost my drug coverage on:
☐	I left coverage from my employer or union (including COBRA coverage). I left or will leave on:
☐	I'm in a qualified State Pharmaceutical Assistance Program (SPAP) or I am losing Extra Help from an SPAP.
☐	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:
☐	I was enrolled in a Special Needs Plan (SNP) and I want to choose a different plan. My enrollment in that plan started on:
☐	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:
☐	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.
☐	I have had Medicare prior to now, but I am now turning 65.
☐	I already have Hospital (Part A) and recently signed up for Medical (Part B). I want to join a Medicare Advantage Plan.
☐	I am in a plan that has had a star rating of less than three stars for the last three years. I want to join a plan with a star rating of three stars or higher.
☐	I requested plan materials in an accessible format and was not given equal time to make an enrollment decision.
☐	Other (please explain):

Select Your Premium Payment Option

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by choosing one of the following options.

If you don't select an option below, and you are currently enrolled on one of our plans, we will keep your current billing option in place. If you are not currently enrolled on one of our plans and you don't select an option below, we will send you a monthly invoice. You can pay that invoice by calling **833-840-1214** (TTY: 711), October 1 to March 31, seven days a week, from 8 a.m. to 8 p.m. and April 1 to September 30, Monday to Friday from 8 a.m. to 8 p.m. or through your MyChart account.

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

The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. You are responsible for paying your premium until we notify you of your start date. 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 that 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.

I get monthly benefits from:

☐

Social Security

☐

RRB

☐

Direct pay

You will receive a monthly invoice for your premium amount. You can pay the invoice by check, by credit card over the phone, or by setting up auto-pay in your MyChart account. Premiums are due by the 1st of the month. You can't set up auto-pay in MyChart until you have been approved to join the plan.

Acknowledgement. Please read and sign below.

- I must keep both Hospital (Part A) and Medical (Part B) to stay in St. Luke's Health Plan, Inc.
- By joining this Medicare Advantage (MA) Plan, I acknowledge that St. Luke's Health Plan, Inc. will share my information with Medicare, who may use it to track my enrollment, to make payment, and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time, and that enrollment in this plan will automatically end my enrollment in another MA plan. Note: exceptions apply for MA Private Fee-for-Service (PFFS) and Medical Savings Account (MSA) plans.
- I understand that when my St. Luke's Health Plan, Inc. coverage begins, I must get all of my medical and prescription drug benefits from St. Luke's Health Plan, Inc. Benefits and services provided by St. Luke's Health Plan, Inc. and contained in my St. Luke's Health Plan, Inc. Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor St. Luke's Health Plan, Inc. will pay for benefits or services that are not covered.

- 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 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:
 1. This person is authorized under state law to complete this enrollment.
 2. Documentation of this authority is available upon request by Medicare.

Signature:

Date:

☐

Affirmation (in lieu of signature): I understand and agree I am enrolling in a St. Luke's Health Plan Medicare Advantage plan. I affirm I am either the beneficiary or a representative of the beneficiary authorized under Idaho state law to complete this enrollment.

Your relationship to the beneficiary:

☐

Self

☐

Authorized Representative

☐

Other (specify):

If you are the Authorized Representative, sign or affirm above and fill out the fields below. If applicable, please attach a power of attorney or other documentation proving authority.

First and Last Name:

Telephone:

Address:

City & State:

Zip:

This section for Agents/Brokers only:

Broker/Agent Name (if assisted in enrollment):

Broker ID:

Broker Email:

Date enrollment form taken by Broker/Agent:

Enrollment performed via:

☐

Telephone/Teleconference

☐

In-person

2027 Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a representative toll-free at **833-840-1216 (TTY: 711)**, October 1 to March 31, seven days a week, from 8 a.m. to 8 p.m. and April 1 to September 30, Monday to Friday from 8 a.m. to 8 p.m.

Understanding the Benefits

☐	The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit medicare.stlukeshealthplan.org to view or call 833-840-1214 (TTY: 711) to request a copy of the EOC.
☐	Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
☐	Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
☐	Review the formulary to make sure your drugs are covered.

Understanding Important Rules

☐	In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
☐	Benefits, premiums and/or copayments/coinsurance may change on January 1, 2028.
☐	Except in emergency or urgent situations, we do not cover services by out-of-network providers. Out-of-network doctors are those that are not listed in our provider directory.
☐	Effect on Current Coverage: if you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

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 422.60 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.