OMB No. 0983-1378
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Individual Enrollment Request Form to Enroll in Viva Medicare

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug 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 3 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 Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in 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 open enrollment (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:

Viva Medicare
417 20th Street North, Suite 1100
Birmingham, AL 35203

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Viva Medicare at 1-888-830-8482. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Viva Medicare al 1-888-830-8482. 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.

VIVA HEALTH®

Medicare Enrollment Application

Office Use Only:
Name of staff member/agent (if assisted in enrollment): _____
Plan ID #: _____
Effective Date of Coverage: _____
ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____ OEP: _____

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

Select the plan you want to join:

☐ VIVA MEDICARE *Plus* (HMO)	$ 0 per month	☐ VIVA MEDICARE *Extra Value* (HMO SNP)	$ 0 per month
☐ VIVA MEDICARE *Select* (HMO)	$ 0 per month	☐ VIVA MEDICARE *Classic* (HMO)	$ 0 per month
☐ VIVA MEDICARE *Prime* (HMO)	$53 per month	☐ VIVA MEDICARE *Extra Care* (HMO SNP)	$ 0 per month
☐ VIVA MEDICARE *Premier* (HMO)	$103 per month	☐ VIVA MEDICARE *Infirmary Health Advantage* (HMO)	$ 0 per month

LAST Name: FIRST Name: Optional: Middle Initial

Birth Date:	Sex:	Home Phone Number:	Cell Phone Number:
(_____/_____/_____) (M M / D D / Y Y Y Y)	☐ M ☐ F	( )	( )

Permanent Residence Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:	County (Optional):	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):

Street Address:	City:	State:	ZIP Code:

Medicare Information

Medicare Number : ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Answer these important questions:

1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to VIVA MEDICARE?
☐ Yes ☐ No

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

_____ _____ _____

2. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If "yes", please provide your Medicaid Number.

Medicaid Number: _____

If enrolling in VIVA MEDICARE *Extra Value* plan or VIVA MEDICARE *Extra Care* plan, please provide your Social Security Number.

Social Security Number:_____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in VIVA MEDICARE.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that VIVA MEDICARE 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 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 (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my VIVA MEDICARE coverage begins, I must get all of my medical and prescription drug benefits from VIVA MEDICARE. Benefits and services provided by VIVA MEDICARE and contained in my VIVA MEDICARE "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor VIVA MEDICARE 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:
  - This person is authorized under State law to complete this enrollment, and
  - Documentation of this authority is available upon request by Medicare.

Electronic Communication: I consent to be contacted by VIVA MEDICARE, or its business associates, for certain health care communications at the phone number (cellular or landline) and email address above (including voice messages made by an auto-dialer or pre-recorded voice and text messages sent to my cellular number). I understand that my phone or internet carrier may charge fees for these communications (I may contact my carrier for pricing plans and details). I understand that VIVA MEDICARE has policies and procedures in place to safeguard my personal health information; however, there are some data security and privacy risks associated with sending and receiving communications about my health care. Communications I send or receive may not be sent and stored securely and may be accessed by third parties. I understand that I may cancel this consent (revoke or opt-out) by contacting VIVA MEDICARE Member Services.

Signature:	**Today's Date:**

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

Name: _____

Address: _____

Phone Number: (_____) _____ - _____ **Relationship to Enrollee** _____

Witness Signature (required if applicant signs with an X):

_____ Date: _____

Section 2 - All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you didn't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer**

What's your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____
- ☐ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

☐ Lesbian or gay
☐ Straight, that is, not gay or lesbian
☐ Bisexual
☐ I use a different term: _____
☐ I don't know
☐ **I choose not to answer**

Please check the box below if you would prefer us to send you information in another accessible format:

☐ Large Print ☐ Audio CD

Please contact VIVA MEDICARE at 1-800-633-1542 if you need information in another format or language than what is listed above. Our hours are Monday through Friday, 8 a.m. to 8 p.m. (from October 1 to March 31, seven days a week, 8 a.m. to 8 p.m.). TTY users should call 711.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center:

_____

Email Address: _____

Paying Your Plan Premium

You can pay your monthly plan premium, including any late enrollment penalty that you currently have or may owe, by mail or by Electronic Funds Transfer (EFT) from your bank 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 VIVA MEDICARE the Part D-IRMAA.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Get a bill each month.

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check and provide the following:

Account holder name: _____

Bank routing number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Bank account number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Account Type: ☐ Checking

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

I get monthly benefits from: ☐ Social Security ☐ RRB

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee: _____

Signature: _____ National Producer Number (Agents/Brokers only):_____

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.