Medicare Advantage Health Plans

MVP® SmartFund MSA® Individual Enrollment Application

Please contact MVP Health Plan (MVP) if you need this information in another language or format, such as Braille.

By completing this Enrollment Application, I agree to the following:

MVP SmartFund MSA 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 only 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 you of any health coverage that I have or may get in the future.

I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

Enrollment in this plan is generally for the entire year. I may leave this plan ("disenroll") during the Annual Enrollment Period that is October 15–December 7 of every year (effective the following January 1) or under certain limited special circumstances, by sending a request in writing to MVP SmartFund MSA. If I choose a Medicare MSA plan and haven't before joined an MSA plan, then change my mind, I may cancel my enrollment by December 15 of the same year by contacting my plan to cancel my enrollment request.

I understand that my enrollment into an MSA plan isn't complete until the bank account is established. I understand that I am enrolling in a plan that doesn't pay for Medicare covered services until a high deductible is met, but MVP Health Plan allows me to use funds in my MSA account to pay for health services. Withdrawals made from the MSA bank account aren't taxed when used for IRS-qualified medical expenses. I would owe income tax and up to a 50% penalty for withdrawals used for non-medical expenses. After the deductible is met, the plan pays 100% of Medicare-covered services.

If I have any questions regarding the initial set-up of my MSA bank account or any of the information in this enrollment form, I should contact MVP Health Plan at **1-800-665-7924** (TTY: 1-800-662-1220).

MVP SmartFund MSA serves a specific service area. If I move out of the area that MVP SmartFund MSA 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 MVP SmartFund MSA I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from MVP SmartFund MSA when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with MVP Health Plan, he/she may be paid based on my enrollment in MVP SmartFund MSA.

I understand that if I disenroll before the end of the plan year (December 31), MVP Health Plan may debit my MSA bank account for a prorated share of the current year's deposit to be returned to Medicare. The debit amount is based on the number of months left in the year after the disenrollment date. I understand that, if I die, my estate will be responsible for any money owed to Medicare. My estate keeps any amount over what is owed to Medicare.

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Please complete Steps 1–5. Complete one enrollment application per applicant.

Step 1: Select the MVP SmartFund MSA Plan in Which You Want to Enroll

☐ **MVP® SmartFund MSA®**	**$0** monthly premium
☐ **MVP® SmartFund MSA® with Optional Rider**	**$30.00** monthly premium

Select the payment method for your monthly premium.

☐ **Bill me.**
(Once enrolled, you can register for an online account at **mvphealthcare.com** and pay your bill online.)

Step 2: Provide Information About Yourself *(Please print)*

Name *(last, first, middle initial)* | Gender ☐ Male ☐ Female | Date of Birth

Permanent Residence Street Address *(PO Box is not allowed)* | Preferred Phone No. ( )

City | State | Zip Code | County

Mailing Address *(if different from Permanent Address)* | City | State | Zip Code

MVP Member ID No. *(if you are a current MVP Medicare Member)* ☐☐☐☐☐☐☐☐☐☐☐

Step 3: Provide Your Medicare Insurance Information

Using your Medicare card, 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.

Name (as it appears on your Medicare card) | Medicare Number

Is Entitled To:

Hospital (Part A) Effective Date | Medical (Part B) Effective Date

Continue to Step 4 on the next page.

Step 4: Read and Provide Answers to these Important Questions

1. To enroll in MVP SmartFund MSA, you may not have other health coverage as described below. Please answer each of the following questions.

A. Are you enrolled in your State's Medicaid program? ☐ **Yes** ☐ **No**

B. Are you receiving Medicare Hospice benefits? ☐ **Yes** ☐ **No**

C. Some individuals may have other health coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or other health benefits that cover all or part of the annual Medicare MSA deductible. If you have any other such coverage, you are not eligible to enroll in MVP SmartFund MSA.

Will you have other coverage in addition to MVP SmartFund MSA? ☐ **Yes** ☐ **No**

If ***Yes***, provide your other coverage and your identification (ID) number(s) for this coverage so we can decide if you are eligible to enroll in MVP SmartFund MSA.

Name of Other Coverage	ID. No. for this Coverage	Group No. for this Coverage

2. Will you reside in the United States for at least 183 days during each year you are enrolled in MVP SmartFund MSA? ☐ **Yes** ☐ **No**

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

4. Have you served in the military? ☐ **Yes** ☐ **No**

5. Do you want information sent to you in a language other than English? ☐ **Spanish** ☐ **Other**

6. Do you want information sent to you in an accessible format? ☐ **Braille** ☐ **Audio CD** ☐ **Large print**

7. Unless otherwise prohibited by law, I consent to the receipt of electronic communications related to my MVP health plan at the email address I provided. I understand that I am entitled to receive paper documents, and that I can set and change my communication preferences at any time by signing in at **mvphealthcare.com** and selecting *Communication Preferences*. I have read and agree to the details outlined in MVP's *Electronic Communications Disclosure*, which is available at **mvphealthcare.com** or by calling MVP at **1-800-TALK-MVP** (1-800-825-5687). ☐ **Yes** ☐ **No**

Preferred Email Address

Continue to Step 5 on the next page.

Step 5: Read the Following, and Provide Your Signature and Authorization

Release of information: By joining this Medicare health plan, I acknowledge and consent to the release, use, and disclosure of my information (which may include prescription information, medical information, HIV, mental health, and/or alcohol and substance abuse information) by MVP or any health care provider involved in caring for me to Medicare, MVP, or any health care providers, or organizations involved in my care, and other plans as is reasonably necessary for MVP or my health care providers to carry out treatment, payment, or health care operations, or as otherwise and to the extent permitted by, and in accordance with, applicable laws, regulations, and rules. I also acknowledge that MVP Health Plan may release my information to Medicare, who may release it for research and other purposes—to the extent permitted by, and in accordance with, applicable laws, regulations, and rules. 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.

Please sign below.

Signature **Today's Date**

If you are the authorized representative, you must sign above and provide the following information about yourself.

Name	Relationship to Enrollee
Address	Preferred Phone No. ( )

Keeping Records: As an authorized representative, it is important that you keep records of when funds in the MSA account are used, as well as how the funds are used.

If you would prefer information in a language other than English or in an accessible format (Braille, audio recording, or large print), please call the MVP Medicare Customer Care Center at **1-800-665-7924** Monday–Friday, 8 am–8 pm. October 1–March 31, call seven days a week, 8 am–8 pm. TTY users call 1-800-662-1220.

MVP Health Care Medicare Sales
220 Alexander Street
Rochester, NY 14607

Office Use Only

Name of Staff Member/Agent/Broker *(if assisted in enrollment)*			Plan ID No.	Effective Date of Coverage
ICEP/IEP	AEP	SEP (type)	Not Eligible	Agent License No.