OMB No. 0938-1378
Expires: 6/30/2026

SHARP Health Plan

2025 Sharp Direct Advantage® Employer Group Enrollment Form

Completing your enrollment is the first step to becoming a Sharp Direct Advantage member. You can enroll by mail, by phone or online. For help completing the enrollment form or to complete your enrollment over the phone, call us at 1-855-562-8853 (TTY/TDD: 711). Or, visit **sharpmedicareadvantage.com/enroll/enroll-online** to enroll online.

This plan is open to all Medicare-eligible City of San Diego retirees, sponsored by the San Diego Public Employee Benefit Association (SDPEBA). SDPEBA membership is not required to join this plan. Please contact Sharp Health Plan if you need information in another language or format (e.g., Braille).

Who can use this form?

People with Medicare who want to join a Medicare Advantage 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 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:

- 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.

Important information:

- The Medicare application is intended for individual coverage only. If you and your spouse/dependent are both applying for coverage, then each of you will need to complete a separate enrollment form.
- **Note**: If your spouse/dependent is not eligible for Medicare, then he/she will need to complete the Non-Medicare/Non-Medicare Retiree enrollment form. Please contact SDPEBA at 1-888-315-8027 or visit **sdpeba.org** to download the enrollment form.

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

What happens next?

Mail your completed and signed form to:

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

Once they process your request to join, a plan representative will contact you.

How do I get help with this form?

Call 1-855-562-8853 (TTY/TDD: 711).

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

En español: Llame a Sharp Health Plan al 1-855-562-8853 (TTY/TDD: 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.

City of San Diego Retiree		
Are you the City of San Diego retiree? ☐ Yes ☐ No		
If you answered no, are you the surviving spouse of a City of San Diego retiree? ☐ Yes ☐ No		
Retiree Last Name:	Retiree First Name:	Retiree Middle Initial:
Are you Medicare eligible? ☐ Yes If yes, complete the enclosed Medicare Enrollment Application. ☐ No If no, complete the Non-Medicare Retiree Enrollment Application (1-888-315-8027/**sdpeba.org**). If yes, are you covering a spouse/dependent? ☐ Yes (If yes, complete the section below.) ☐ No		
Spouse/Dependent of City of San Diego Retiree		
Last Name:	First Name:	Middle Initial:
Are you Medicare eligible? ☐ Yes If yes, complete an additional Medicare Enrollment Application. ☐ No If no, complete the Non-Medicare Retiree Enrollment Application (1-888-315-8027/**sdpeba.org**).		

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SHARP Health Plan

2025 Sharp Direct Advantage® Employer Group Enrollment Form

To Enroll in Sharp Direct Advantage, Please Provide the Following Information:			
Effective Date of Coverage: MM/DD/YY (/ 01 /)			
Employer or Union Name: **San Diego Public Employee Benefit Association (SDPEBA)**			
I would like to enroll in the following plan: ☑ Sharp Direct Advantage (HMO) ($208 per month) (21955)	This plan is for Medicare-enrolled retirees only. If you are not eligible for Medicare, please contact SDPEBA at 1-888-315-8027 for the Non-Medicare Enrollment Form or visit **sdpeba.org** to download the enrollment form.		
Last Name:	First Name:		Middle Initial:
Birth date: MM/DD/YY / /	Social Security number: – –	Sex: ☐ Male ☐ Female	
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	County:	State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Street Address):			
City:	State:	ZIP Code:	
Cell Phone Number: ( )	Home Phone Number: ( )		
Other Phone Number: ( )	Email Address:		

Please Provide Your Medicare Insurance Information	
Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card. - OR - • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card): _____ Medicare Number: _____ Is Entitled To: Effective Date Hospital (Part A): _____ Medical (Part B): _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

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

Please Read and Answer These Important Questions:

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

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

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

☐ **Yes** ☐ **No** If yes, name of spouse/dependent(s): _____

If you intend to cover a Medicare or non-Medicare eligible spouse/dependent, then he/she will need to complete a separate enrollment application (Medicare or Non-Medicare).

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

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 Direct 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: _____

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): _____

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.

Please check one of the boxes below if you would prefer us to send you future information in a language other than English or in an accessible format:

☐ Spanish ☐ Accessible Format (e.g., Braille, Audio or Large Print): _____

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

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

What's your race? Select all that apply.

☐ American Indian or Alaska Native
☐ Asian Indian
☐ Black or African American
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean
☐ Native Hawaiian
☐ Other Asian
☐ Other Pacific Islander
☐ Samoan
☐ Vietnamese
☐ White
☐ **I choose not to answer.**

Please contact Sharp Health Plan at 1-855-562-8853 if you need information in an accessible format or language other than what is listed above (TTY/TDD users should call 711). Our hours of operation are 7 a.m. to 8 p.m., seven days a week, all year round.

Sharp Health Plan is an HMO plan with a Medicare contract. Enrollment in Sharp Health Plan 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. Sharp Health Plan provides the Evidence of Coverage, Formulary and Provider Directory online at **sharpmedicareadvantage.com**. Members can request a paper copy be mailed to them by calling Customer Care at the phone number listed above.

Please Read and Answer These Important Questions:

Typically, you may enroll in a Medicare Advantage plan only during the City of San Diego Medicare retirees' open enrollment period, which is in November 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 (November 1 - 30, 2024).
- ☐ I am new to Medicare.
- ☐ I am leaving employer or union coverage on (insert date) _____.

If none of these statements apply to you or you're not sure, please contact Sharp Health Plan at 1-855-562-8853 (TTY/TDD users should call 711) to see if you are eligible to enroll. Our office hours are Oct. 1 – March 31 from 8 a.m. – 8 p.m. Pacific time, seven days a week and April 1 – Sept. 30 from 8 a.m. – 8 p.m., Monday through Friday. Calling after hours will direct you to our voicemail system, and a Customer Care representative will return your call the next business day.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

Sharp Direct 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 (e.g., annual enrollment period), or under certain special circumstances.

Sharp Direct Advantage serves a specific service area. If I move out of the area that Sharp Direct Advantage serves, I need to notify the plan so I can disenroll and find a plan in my new area. Once I am a member of Sharp Direct 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 Direct Advantage when I get it to understand the 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 from the date Sharp Direct Advantage coverage begins, I must get all of my health care from Sharp Direct Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Sharp Direct Advantage and other services contained in my Sharp Direct Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR SHARP DIRECT 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 Direct Advantage, he/she may be paid based on my enrollment in Sharp Direct Advantage.

Please Read and Sign Below, continued

The undersigned expressly consents and agrees that Sharp Health Plan, its business associates and other third parties, including debt collectors, may send periodic electronic communications for any lawful purpose, including routine business and/or marketing purposes, to any email address or phone number he/she provides. Messages may be sent by text (SMS), email, automatic telephone dialing systems (auto-dialer), prerecorded message or live operator call. Message frequency will vary. Message and data rates apply. The undersigned may opt out of receiving further automated, electronic communications at any time by texting STOP or calling 1-800-827-4277. Whether the undersigned agrees to receive these messages will not affect care or coverage in any way. Visit www.sharphealthplan.com/terms for complete terms of use.

Release of Information: By joining this Medicare health plan, I acknowledge that Sharp Direct 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 Direct Advantage will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that 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 in which 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: ( )

Next Steps

- We'll review your form to ensure it's complete. Then we'll let you know by mail that we've received it.
- We'll let Medicare know that you've applied for Sharp Direct Advantage.
- Within 10 calendar days of Medicare confirming your eligibility, we'll let you know when your coverage starts. Then, we'll send your Sharp Direct Advantage ID card and information for new members.

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

Nondiscrimination 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 (such as large print, audio, accessible electronic formats or 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 Customer Care at 1-855-562-8853

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 our Civil Rights Coordinator at:

- Address: Sharp Health Plan Appeal/Grievance Department, 8520 Tech Way, Suite 200, San Diego, CA 92123-1450
- Telephone: 1-855-562-8853 (TTY/TDD: 711)
  Fax: 1-619-740-8572

You can file a grievance in person or by mail or fax, or you can also complete the online Grievance/Appeal form on the Plan's website **sharphealthplan.com**. Please call our Customer Care team at 1-855-562-8853 if you need help filing a grievance. 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 Insert

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 1-855-562-8853. 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 1-855-562-8853. 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 1-855-562-8853。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 1-855-562-8853。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

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 1-855-562-8853. 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 1-855-562-8853. 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 1-855-562-8853 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 1-855-562-8853. 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 1-855-562-8853 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 1-855-562-8853. 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 1-855-562-8853. 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 1-855-562-8853 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 1-855-562-8853. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: 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 1-855-562-8853. 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 1-855-562-8853. 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 1-855-562-8853. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 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。通訳をご用命になるには、1-855-562-8853 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。