OMB No. 0938-1378
Expires: 7/31/2026

SHARP HEALTH PLAN

EGWP Sharp HealthCare ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

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 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 receive 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?

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.

Agent information — internal use only:

Name of staff member (if assisted in enrollment) _____ CA License #: _____

Plan ID #: _____ Receive date: _____ ICEP/IEP: ____ SEP (type): ____ Not eligible: ____

PCP #: _____ Application #: _____

To enroll in Sharp Direct Advantage, please provide the following information:

Employer or union name: Sharp HealthCare former employees	Group #: 1002010
Requested start date of coverage: MM/DD/YYYY (/ /)	

Select the plan you want to join:

☐ Sharp Direct Advantage Basic ($0 per month, Dental not included)

☐ Sharp Direct Advantage Basic with Dental ($13 per month, Delta Dental Medicare Advantage DHMO*)

☐ Sharp Direct Advantage Basic with Dental ($40 per month, Delta Dental Medicare Advantage PPO)

☐ Sharp Direct Advantage Premium ($71 per month, Dental not included)

☐ Sharp Direct Advantage Premium with Dental ($84 per month, Delta Dental Medicare Advantage DHMO*)

☐ Sharp Direct Advantage Premium with Dental ($111 per month, Delta Dental Medicare Advantage PPO)

*The comprehensive dental coverage is provided through DeltaCare USA, an HMO-type plan offered by Delta Dental of California. You will be auto-assigned a network dentist in your area. If you would like to change to another network provider, contact Delta Dental.

First name:	Last name:	Middle initial:	☐ Mr. ☐ Ms. ☐ Mrs.
Birth date: MM/DD/YYYY / /	Sex: ☐ Male ☐ Female	Email address:	
Cell phone number: ( )	Home phone number: ( )	Other phone number: ( )	
Permanent residence street address (don't enter a PO Box):			
City:	County:	State:	ZIP code:
Mailing address, if different from your permanent address (PO Box allowed): Street address:			
City:	State:	ZIP code:	
Social Security number:			

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) _____

Please read and answer these important questions:

1. Are you the former employee of Sharp HealthCare? ☐ Yes ☐ No

If yes, employment end date (MM/DD/YY): _____

If no, name of former Sharp HealthCare employee: _____

2. Please only answer this question if you are the former employee. Are you covering a spouse or dependent(s) under this employer plan? ☐ Yes ☐ No

If yes, name of spouse: _____

Name(s) of dependent(s):_____

Name(s) of dependent(s) employer:_____

Note: The spouse/dependent of the former employee will need to complete a separate application.

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

4. 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 Health Plan? ☐ Yes ☐ No

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

Name of other coverage: ID # for coverage:

_____ _____

5. 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: _____

Address and phone number of institution (number and street): _____

Please choose a **Sharp HealthCare** primary care physician (PCP):

PCP name: _____ PCP medical group: _____

Are you a current patient? ☐ Yes ☐ No

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Sharp Health Plan.
- By joining this Medicare Advantage plan, I acknowledge that Sharp Health Plan 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 Sharp Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Sharp Health Plan. Benefits and services provided by Sharp Health Plan and contained in my Sharp Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Sharp Health Plan 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, and
  2) Documentation of this authority is available upon request by Medicare.
- 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 messages or live operator calls. 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.

Signature: **x**	**Today's date:**

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

Name:	Address:
Phone number: ( )	Relationship to enrollee:

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

☐ Spanish

☐ Accessible format (like Braille, audio or large print): _____

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

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 or Chicano/a
☐ Yes, Cuban
☐ **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.**

Attestation of eligibility for an enrollment period:

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 statement carefully and check the box if the statement applies to you.

By checking the following box, 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 former employee or spouse/domestic partner/dependent of a former employee of Sharp HealthCare and I am not actively employed by Sharp HealthCare.

If this statement does not apply to you or you're not sure, please contact Sharp Health Plan at 1-855-562-8853 (TTY/TDD: 711) to see if you are eligible to enroll. Our hours of operation are 7 a.m. to 8 p.m., seven days a week, all year round.