DeanHealthPlan
A member of SSM Health

Short Enrollment Request Form

Dean Advantage
Prevea360 Medicare Advantage
Medicare Coverage from Dean Health Plan

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

Return to:
Dean Health Plan - Enrollment
PO Box 851078 | Richardson, TX 75085-1078

Name of the plan you are enrolling in

Please select **Dean Advantage** if you live in Columbia, Dane, Dodge, Fond du Lac, Green, Iowa, Jefferson, Rock or Sauk county. ** Dean Advantage SSM Presence only available in Dodge and Fond du Lac*

- ☐ Dean Advantage **Essential (HMO)**
- ☐ Dean Advantage **Assurance (HMO-POS)**
- ☐ Dean Advantage **Balance (HMO-POS)**
- ☐ Dean Advantage **Complete (HMO)**
- ☐ Dean Advantage **Harmony (HMO-POS) MA-Only**
- Dean Advantage **SSM Presence (HMO-POS)***

Please select **Prevea360 Medicare Advantage** if you live in Brown, Chippewa, Door, Eau Claire, Kewaunee, Oconto or Sheboygan county.

- ☐ Prevea360 Medicare Advantage **Essential (HMO-POS)**
- ☐ Prevea360 Medicare Advantage **Harmony (HMO-POS) MA-Only**

Last name	**First name**	**Middle initial**

Member Number	**Home Phone**	**Email** (consenting to be contacted and will have opt-out rights)

Permanent street address (P.O. Box is not allowed)

Street	City	County	State, ZIP code

Mailing address (only if different from your permanent address)

Street Address	City	County	State, ZIP code

Please fill out the following:

I am currently a member of the _____ plan from Dean Health Plan

with a monthly premium of $ _____ .

I would like to change to the_____ plan from Dean Health Plan.

I understand that this plan has different health benefits and a monthly premium of $_____

Name of chosen Primary Care Physician (PCP), clinic or health center:

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

☐ Other language: ☐ Large print ☐ Braille

_____

Please contact Dean Health Plan at 1-877-232-7566 (TTY: 711) f you need information in an accessible format or language other than what is listed above.

Your plan premium:

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail, Electronic Funds Transfer (EFT), or debit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board. Do NOT pay Dean Advantage the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

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

Please select a premium payment option:

☐ **Get a bill**	☐ **Electronic Fund Transfer (Automatic premium withdrawal)** If selecting this method, please complete the Automatic Premium Withdrawal Authorization form. If an EFT is already active with Dean Health Plan, a new form is not needed unless account information has changed.

Automatic deduction from your monthly Social Security or RRB benefit check.
I get monthly benefits from:

☐ **Social Security**
☐ **RRB**

(The Social Security deduction may take two or more months to begin after Social Security or RRB approves the deduction. 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 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.)

Stop: Please read and sign below.

Once Dean Health Plan has your enrollment form, a plan representative will call you. This call is to make sure that you understand how a Private Fee-for-Service plan works and to confirm your intent to enroll in Dean Health Plan. If Dean Health Plan isn't able to reach you by telephone, then you will get a letter by mail that contains similar information.

Dean Health Plan is a plan that has a contract with the Federal government.

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

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Dean Health Plan will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which 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 people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Dean Health Plan coverage begins, I must get all of my health care from Dean Health Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Dean Health Plan and other services contained in my Dean Health Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR DEAN HEALTH PLAN WILL PAY FOR THE SERVICES**.

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.

Signature	**Today's Date**

If you are the authorized representative, you must sign above and provide the following information:

Name

Address	**Phone Number**

Relationship to Enrollee

OFFICE USE ONLY

Name of staff member/agent/broker (if assisted in enrollment)	**Agent ID number**	**Effective Date of Coverage**

☐ ICEP/IEP	☐ AEP	☐ SEP	☐ Not Eligible	Date Recieved