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

2025 Enrollment Request Form

Use this form to enroll in an Essence Healthcare plan.

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 get your completed form by December 7.
- Your plan will send you a monthly invoice for the plan's premium and any applicable Late Enrollment Penalty. 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:

Essence Healthcare
P.O. Box 12487
St. Louis, MO 63132

You can also enroll online at EssenceHealthcare.com.

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

How do I get help with this form?

Call Essence Healthcare at 1-855-770-7671. 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 Essence Healthcare al 1-855-770-7671 (TTY: 711) o a Medicare gratis al 1-800-633-4227 y oprima el 8 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.

Please contact Essence Healthcare Sales at 1-855-770-7671 if you need assistance completing this form. TTY users can call the national relay service toll-free at 711.

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

Select the plan you want to join:

☐ Essence *Advantage*® (HMO) H2610-021 (Louisville and Lexington Areas*) – $0 per month

☐ Essence *Advantage*® *Choice* (PPO) H6200-006 (Louisville and Lexington Areas*) – $0 per month

*Includes the Kentucky counties of Anderson, Bourbon, Bullitt, Carroll, Clark, Fayette, Harrison, Henry, Jefferson, Larue, Meade, Mercer, Nelson, Oldham, Owen, Robertson, Shelby, Spencer, Trimble, Washington and Woodford, and the Indiana counties of Clark, Crawford, Floyd, Harrison, Jefferson, Ripley, Scott, Switzerland and Washington

Your Information

FIRST Name:	LAST Name:	Middle Initial (Optional):

Birth Date (MM/DD/YYYY): __ __/__ __/__ __ __ __	Phone Number (Select primary phone number):
Sex: ☐ Male ☐ Female	☐ Mobile (__ __ __) __ __ __ - __ __ __ __
	☐ Home (__ __ __) __ __ __ - __ __ __ __

Permanent Residence street address (Don't enter a P.O. Box. Note: Individuals experiencing homelessness may enter a P.O. Box - the plan will need to confirm your residency in the service area.)	County (Optional):

City:	State:	Zip Code:

Mailing Street Address, if different from your permanent address (P.O. Box allowed):

City:	State:	Zip Code:

E-mail address (Optional):

Save paper, go paperless! (Optional)

☐ **Email Opt-In: Member Communications** I want to receive important reminders, benefit education information, program discounts, and general health information by email.

Your Medicare Information

Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Essence Healthcare? ☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage. If you have coverage through TRICARE, the VA, or an employer/union, your coverage may be affected once your MA coverage starts. Please contact TRICARE, the VA, or your employer/union for more information.

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

IMPORTANT: Read and Sign Below:

- Essence Healthcare has a contract with the Federal government. I must keep both Hospital (Part A) and Medical (Part B) to stay in Essence Healthcare.
- By joining this Medicare Advantage plan, I acknowledge that Essence Healthcare will share my information with Medicare, who may use it to track my enrollment, and with other plans 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.
- 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 are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Essence Healthcare coverage begins, I must get all of my medical and prescription drug benefits from Essence Healthcare. Benefits and services provided by Essence Healthcare and contained in my Essence Healthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Essence Healthcare will pay for benefits or services that are not covered. Emergency and urgent care coverage, both within and outside the plan's service area, are always covered. I will read the Evidence of Coverage document from Essence Healthcare when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. You can also find the Evidence of Coverage, Star Ratings and Summary of Benefits for an Essence plan at EssenceHealthcare.com.
- Once I am a member of Essence Healthcare, I understand that I have the right to appeal plan decisions about payment or services if I disagree.
- I understand that I can be enrolled in only one MA or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan.
- I understand that if I am getting assistance from a sales agent or broker, he/she may be compensated based on my enrollment in Essence Healthcare.
- 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.

Signature:	**Today's Date:**

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

Name:

Address:	Relationship to Enrollee:	Phone Number:

Section 2 – All fields in this section are optional

Answering these questions is your choice.
You cannot be denied coverage because you do not fill them out.

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

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

What is 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

Communication Options:

Select one if your preferred spoken language is a language other than English.

☐ Arabic	☐ Chinese	☐ French	☐ French Creole
☐ German	☐ Gujarati	☐ Korean	☐ Polish
☐ Portuguese	☐ Spanish	☐ Tagalog	☐ Vietnamese

Select one if you want us to send you information in a language other than English.

☐ Arabic	☐ Chinese	☐ French	☐ French Creole
☐ German	☐ Gujarati	☐ Korean	☐ Polish
☐ Portuguese	☐ Spanish	☐ Tagalog	☐ Vietnamese

Select one if you want us to send you information in an accessible format.

☐ Audio ☐ Braille ☐ Data ☐ Large Print

Please contact Essence Healthcare at 1-855-770-7671 if you need information in an accessible format or language other than what is listed above or if your preferred spoken language is a language other than those listed above. Our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week. You may receive a messaging service on weekends from April 1 through September 30 and holidays. TTY users can call 711.

List your primary care physician (PCP), clinic or health center:

Primary Care Physician (PCP):

Dr. _____
(First Name) (Last Name)

PCP # from Provider Directory:

Is this your current physician?

☐ Yes ☐ No

STOP PLEASE READ THIS IMPORTANT INFORMATION STOP

If you currently have health coverage from an employer or union, joining Essence Healthcare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Essence Healthcare. Read the communications your employer or union sends you. If you have questions, visit their website or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Paying your plan premiums

Whether you are enrolled in a premium or non-premium plan, you may pay your plan premium and any applicable Late Enrollment Penalty that you have or may owe **by automatic deduction from your Social Security (SSA) or Railroad Retirement Board (RRB) benefit check.** You may also choose to pay by Electronic Funds Transfer (EFT) from your bank, Credit card, Debit card, or check via mail 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 Essence Healthcare the Part D-IRMAA.

Please select a premium payment option:

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

I get monthly benefits from: ☐ Social Security ☐ RRB

It can take up to 90 days to receive SSA/RRB withhold acceptance. SSA/RRB will begin deducting on the date of acceptance. Members will receive an invoice for any months prior to the withhold acceptance date by SSA/RRB, which will be their responsibility to pay. In limited circumstances, Medicare may not allow for the SSA/RRB deduction option and may instruct the plan to directly bill the member. If this occurs, you will be notified in writing. If you select this payment option, you will not receive a monthly invoice.

☐ **Electronic Funds Transfer (EFT) from your bank account each month**

If you choose to have the funds taken directly out of your checking account, this is referred to as Electronic Funds Transfer (EFT). If you elect this method of payment, you will receive a letter from the plan requesting a Voided Check be returned with the letter for account setup. Do not submit a voided check at time of enrollment. Your request will be processed within 60 business days of receipt of returned voided check and letter. Premiums are deducted from your bank account on the 2nd day of the month for the current month's coverage. If you select this payment option, you will not receive a monthly invoice.

☐ **Direct Pay**

A monthly invoice will be mailed to you and you can choose whether to pay by check, money order, or online.

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) Plans, 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.

FOR OFFICE USE ONLY						
Confirmation # (Quick Entry or Phone Enroll):			**Application Log #**:		**Plan Receipt Date:**	
Plan ID #:			**Effective Date of Coverage:**			
Election Periods:	☐ **ICEP (I)**	☐ **IEP (E)**	☐ **2nd IEP (F)**	☐ **AEP (A)**	☐ **OEP (M)**	☐ **OEPI (T)**

Special Election Periods (Must check all that apply)**:**

SEP (S)

☐ SPAP (38)
☐ Retro Entitlement (32)
☐ Contract/Plan Non-Renewal (12)
☐ Contract Term – Immediate (11)
☐ Contract Term – CMS (11)
☐ CMS Identified Consistent Poor Performing Plan (40)
☐ Cost Plan Non-Renewal (28)
☐ Lawfully Present (37)
☐ Loss of SNP (35)
☐ Involuntary Loss/Cred. Coverage (22)
☐ Contract Term – MAO (12)
☐ Plan Placed in Receivership (39)
☐ Accessible Format Delay (21)
☐ PACE Transition (27)
☐ Part B General Enrollment (34)

SEP (V)

☐ Permanent Move

SEP (W)

☐ Gain or Loss of Employer Coverage

SEP (U)

☐ Gain/Loss/Change in Dual Eligible Status
☐ Gain/Loss/Change in Non-Dual LIS
☐ Gain/Loss/Change of Medicaid

SEP (R)

☐ 5-Star SEP

Producer Name:	**Producer NPN:**	**Application Receipt Date:**