South Country HEALTH ALLIANCE

# 2026

# AbilityCare (HMO D-SNP) Enrollment Form

## South Country Health Alliance Member Services Telephone Numbers

**1-866-567-7242. TTY for the hearing impaired at 1-800-627-3529 or 711.**

Hours of service are:
October - March, 7 days a week, 8 a.m. - 8 p.m.;
April - September, Monday - Friday, 8 a.m. - 8 p.m.

The call is free.

## Return the completed form, page numbers 1 to 5, to:

South Country Health Alliance
6380 W Frontage Rd
Medford, MN 55049

Fax: 507-431-6328

H5703_7385_C AbilityCare (HMO D-SNP) is a health plan that contracts with both Medicare and the Minnesota Medical Assistance Program to provide benefits of both programs to enrollees. Enrollment in AbilityCare depends on contract renewal.

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# NO ENGLISH ☎ 1-866-567-7242

# TRS: 711

ATTENTION: If you speak English, free language assistance services are available to you free of charge and without unnecessary delay. Additionally, appropriate auxiliary aids and services to provide information in accessible formats are available free of charge and in a timely manner. Please call the number above or speak to your provider. English

ማሳሰቢያ፦ አማርኛ ተናጋሪ ከሆኑ ፤ ነጻ የቋንቋ ድጋፍ አገልግሎቶች ካለምንም ክፍያ እና ካለአላስፈላጊ መዘግየት ማግኘት ይችላሉ። በተጨማሪም መረጃን በቀላሉ ለማግኘት በሚያስችል ቅርጸት ለማቅረብ ተገቢ የሆኑ የመስማት ድጋፍ እና አገልግሎቶች ከክፍያ ነጻ በሆነ እና ግዜውን በጠበቀ መልኩ ማግኘት ይችላሉ። እባክዎ ከላይ ባለው ቁጥር ይደውሉ ወይም አቅራቢዎን ያነጋግሩ። Amharic

**تنبيه:** نقدم لمتحدثي اللغة العربية خدمات مساعدة لغوية مجانية وفورية، بالإضافة إلى وسائل وخدمات مساعدة مناسبة، وبصيغة معلومات سهلة بدون تكلفة وبشكل سريع. يرجى التواصل على الرقم الموضح أعلاه أو مراجعة مقدم الخدمة المباشرة. Arabic

သတိပြုရန် – အကယ်၍ သင်သည် မြန်မာဘာသာစကား ပြောဆိုသူဖြစ်လျှင် အခမဲ့ ဘာသာစကားဆိုင်ရာ ပံ့ပိုးထောက်ပံ့ပေးမှု ဝန်ဆောင်မှုများအား မလိုအပ်သည့် နှောင့်နှေးကြန့်ကြာမှုများ မရှိစေဘဲ သင် အခမဲ့ ရရှိနိုင်မည် ဖြစ်သည်။ ထို့ပြင် အချက်အလက်များအား အလွယ်တကူ ဝင်ရောက်ရယူနိုင်စေသော ဖောမတ်ပုံစံများဖြင့် ထောက်ပံ့ပေးထားသည့် သက်ဆိုင်ရာ ဖြည့်စွက် ထောက်ပံ့မှုများနှင့် ဝန်ဆောင်မှုများကိုလည်း အခမဲ့၊ အချိန်မရရှိနိုင်စေရန် စီမံပေးထားပါသည်။ ကျေးဇူးပြုပြီး အထက်ဖော်ပြပါ ဖုန်းနံပါတ်သို့ ခေါ်ဆိုပါ သို့မဟုတ် သင်၏ ထောက်ပံ့သူဖြင့် ပြောဆိုဆွေးနွေးပါ။ မြန်မာဘာသာစကား Burmese

យកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (ខ្មែរ) សេវាកម្មជំនួយភាសាឥតគិតថ្លៃមានផ្តល់ជូនអ្នកដោយមិនគិតថ្លៃ និងដោយភ្ជាន់ការពន្យារពេលមិនចាំបាច់ឡើយ។ លើសពីនេះ ជំនួយ និងសេវាកម្មដែលសមស្របក្នុងការផ្តល់ព័ត៌មានក្នុងទម្រង់ដែលអាចចូលប្រើបានគឺអាចរកបានដោយឥតគិតថ្លៃ និងទាន់ពេលវេលា។ សូមហៅទូរសព្ទទៅលេខខាងលើ ឬនិយាយជាមួយអ្នកផ្តល់សេវារបស់អ្នក។ ភាសាខ្មែរ (ខ្មែរ) Cambodian (Khmer)

注意：如果您說簡體中文，您可以免費獲得語言協助服務，且不會有不必要的延誤。此外，還能免費及時獲取以無障礙格式提供資訊的適當輔助工具和服務。請撥打上面的電話號碼，或與您的服務提供商溝通。 Cantonese (Traditional Chinese)

ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition, sans frais et sans délai. En outre, des aides et services auxiliaires appropriés pouvant fournir des informations dans des formats accessibles sont disponibles gratuitement et rapidement. Veuillez appeler le numéro ci-dessus ou contacter votre fournisseur. French

CEEB TOOM: Yog koj hais lus Hmoob, muaj kev pab txhais lus dawb rau koj siv. Koj tsis tas them nqi thiab yuav tsis qeeb. Kuj muaj cuab yeej thiab kev pab los pab koj nyeem cov ntaub ntawv kom yooj yim nkag siab. Koj hu tau rau tus xov tooj saum toj no lossis nrog koj tus kws kho mob tham. Hmong

**NO ENGLISH**  **1-866-567-7242**

**TRS: 711**

ဟ်သူဉ်ဟ်သး– နမ့ၢ်ကတိၤကညီကျိာ်အဃိ, နမၤန့ၢ် ကျိာ်တၢ်ဆိဉ်ထွဲမၤစၢၤ လၢတလာ်ဘူဉ်လာ်စ့ၤ ဒီးတအိဉ်ဒီး တၢ်မၤယဲာ်မၤနီၢ်သးဘဉ်နၣ်လီၤ. အါန့ၢ်အနၣ်, တၢ်အိဉ်စ့ၢ်ကီးဒီး တၢ်မၤစၢၤတၢ်နၢ်ဟူဒီး တၢ်မၤစၢၤတၢ်မၤတဖဉ် လၢကဟ့ဉ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢပှၤအါဂၤန်ၢ်ပၢၢ်အီၤသ့ လၢတအိဉ်ဒီးအဘူးအလဲ ဒီးချူးဆၢချူးကတိၤန့ဉ်လီၤ. ဝံသးစူၤ ကိးနိဉ်ဂံၢ်လၢထး မ့တမ့ၢ် တဲသကိးတၢ်ဒီး ပှၤလၢအဟ့ဉ်နၤတၢ်မၤစၢၤ တက့ၢ်. ကညီကျိာ် Karen

안내: 한국어를 사용하시는 분께는 언어 지원 서비스를 무료로, 지체 없이 제공해 드립니다. 또한, 정보 접근성을 위한 적절한 보조 기구 및 서비스가 무료로, 시의적절하게 제공됩니다. 위에 있는 번호로 전화하시거나 담당자에게 말씀해 주십시오. Korean

ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານຈະໄດ້ຮັບບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າ ແລະ ບໍ່ມີການຊັກຊ້າ ທີ່ບໍ່ຈຳເປັນ. ນອກຈາກນັ້ນ, ເຄື່ອງມືຊ່ວຍເຫຼືອແລະ ບໍລິການເສີມທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ເຂົ້າເຖິງໄດ້ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ ແລະ ທັນເວລາ. ກະລຸນາໂທຫາເບີໂທລະສັບຂ້າງເທິງ ຫຼື ສົນທະນາກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ. Lao

HUBADHAA: Yoo Afaan Oromoo dubbattu ta'e, tajaajila gargaarsa turjumaana afaanii biliisaan akkasumas turtii barbaachisaa hin taane hambisu danda'u isiniif dhihaatee jira. Dabalataanis, odeeffannoo haala salphaan argamuu danda'an dhiyeessuuf gargaarsa fi tajaajiloota deeggarsaa qama midhamtootaaf mijatoo ta'an, kaffaltii tokko malee fi yeroo isaa eeggatee kennamu dhihaatee jira. Odeeffanno dabalataaf lakkoofsa armaan oliitti fayyadamuun namoota gargaarsa kana isiniif kennan qunnamaa. Oromo

ВНИМАНИЕ: Если вы разговариваете на русском языке, воспользуйтесь услугами языковой поддержки бесплатно и без лишних проволочек. Также бесплатно и незамедлительно предоставляются соответствующие вспомогательные средства и услуги по обеспечению информацией в доступных форматах. Позвоните по указанному выше номеру или обратитесь к своему поставщику услуг. Russian

FIIRO GAAR AH: Haddii aad ku hadasho Soomaali, waxaa si bilaash ah kuugu diyaar ah adeegyada caawinada luuqadeed oo aan lahayn daahitaan aan munaasib ahayn. Intaas waxaa dheer, waxaa la heli karaa adeegyada iyo kaabitaanka naafada ee haboon si macluumaadka loogu bixiyo qaabab la adeegsan karo oo bilaash ah laguna bixinayo waqqigeeda. Fadlan wac lambarka kore ama la hadal adeegbixiyahaaga. Somali

ATENCIÓN: si habla español, tiene a su disposición los servicios gratuitos de traducción sin costo alguno y sin demoras innecesarias. Además, se encuentran disponibles de forma gratuita y oportuna ayuda y servicios auxiliares adecuados con el fin de brindarle información en formatos accesibles. Llame al número indicado anteriormente o hable con su proveedor. Spanish

LƯU Ý: Nếu bạn nói tiếng Việt, bạn có thể được hỗ trợ ngôn ngữ miễn phí mà không phải chờ đợi lâu. Ngoài ra, các thiết bị hỗ trợ và dịch vụ phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận cũng có sẵn miễn phí và kịp thời. Vui lòng gọi số điện thoại phía trên hoặc trao đổi với nhân viên y tế của bạn. Vietnamese

## Civil Rights Notice

**Discrimination is against the law. South Country Health Alliance (South Country)** does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by South Country. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

Civil Rights Coordinator
South Country Health Alliance
6380 West Frontage Road, Medford, MN 55049
Toll Free: 866-567-7242 TTY: 800-627-3529 or 711 Fax: 507-444-7774
Email: grievances-appeals@mnscha.org

**Auxiliary Aids and Services: South Country** provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact** Member Services at members@mnscha.org or call 866-567-7242, TTY 800-627-3529 or 711.

**Language Assistance Services: South Country** provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** Member Services at members@mnscha.org or call 866-567-7242, TTY 800-627-3529 or 711.

## Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by South Country. You may also contact any of the following agencies directly to file a discrimination complaint.

**U.S. Department of Health and Human Services Office for Civil Rights (OCR)**

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion (in some cases)

Contact the **OCR** directly to file a complaint:

Office for Civil Rights, U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240 Chicago, IL 60601
Customer Response Center: 800-368-1019, TTY: 800-537-7697
Email: ocrmail@hhs.gov

**Minnesota Department of Human Rights (MDHR)**

In Minnesota, you have the right to file a complaint with the MDHR if you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201, St. Paul, MN 55104
651-539-1100 (voice), 800-657-3704 (toll-free), 711 or 800-627-3529 (MN Relay), 651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

**Minnesota Department of Human Services (DHS)**

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- religion (in some cases)
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

Member Name: _____ MHCP Member Number: _____ Clear Form

# 2026 AbilityCare (HMO D-SNP) Enrollment Request Form

OFFICE USE ONLY - DATE STAMP AREA - OFFICE USE ONLY - DATE STAMP AREA - OFFICE USE ONLY - DATE STAMP AREA - OFFICE USE ONLY - DATE

To join AbilityCare, you must have **Medicare Part A**, **Medicare Part B**, and **Medical Assistance without a medical spenddown**, **and** be at least 18 and under age 65, have a certified disability through the Social Security Administration or the State Medical Review Team, **and** live in AbilityCare's service area. You must also be a United States citizen or be lawfully present in the U.S.

**Section 1. Tell us about yourself:**

| | | |
|---|---|---|
| 1 | **Name: (first, middle, last)** | |
| 2 | **Date of birth: (**M M / D D / Y Y Y Y**)**<br>M M D D Y Y Y Y | **Sex:** ☐ **Female** ☐ **Male** |
| 3 | **Phone number:**<br>( _____ ) _____ - _____ | **Another phone number (optional):**<br>( _____ ) _____ - _____ |
| 4 | **Address where you live (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):** | |
| | **City:** / **State:** / **ZIP code:** / **County:** | |
| 5 | **Address where you get mail (if different from where you live):** | |
| | **City:** / **State:** / **ZIP code:** / **County:** | |
| 6 | **Do you live in a long-term care facility?** ☐ **Yes** ☐ **No** If Yes, fill in the information below:<br>**Name of the facility:** **Phone number:** ( _____ ) _____ - _____ | |
| 7 | **Do you need an interpreter?** ☐ **Yes** ☐ **No** If Yes, check the language below: | |
| | ☐ 01 Spanish<br>☐ 02 Hmong<br>☐ 03 Vietnamese<br>☐ 04 Khmer (Cambodian)<br>☐ 05 Lao<br>☐ 06 Russian<br>☐ 07 Somali<br>☐ 08 ASL (American Sign Language)<br>☐ 09 Amharic<br>☐ 10 Arabic<br>☐ 12 Oromo<br>☐ 14 Burmese<br>☐ 15 Cantonese<br>☐ 16 French<br>☐ 20 Korean<br>☐ 21 Karen<br>☐ 98 Other _____ | |
| 8 | **Authorized Representative**: | **Authorized Representative phone number:**<br>( _____ ) _____ - _____ |

Member Name: _____ MHCP Member Number: _____

**Section 2. Tell us more about yourself:**

**You are not required to answer questions or give any information in this section. It's your choice to share this information with us.** We can't deny you coverage if you don't answer them.

| | |
|---|---|
| **9** | **Do you want us to send you information in a language other than English?** ☐ **Yes** ☐ **No**<br>If Yes, write language: _____ |
| **10** | **Do you want us to send you information in an accessible format?** ☐ **Yes** ☐ **No**<br>If Yes, check format below.<br>☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD<br>Please contact AbilityCare at 1-866-567-7242 if you need information in an accessible format other than what's listed above. Our office hours are 7 days a week, 8 a.m. - 8 p.m. (October – March) ; Monday - Friday, 8 a.m. - 8 p.m. (April - September). TTY users can call 1-800-627-3529 or 711. |
| **11** | **Do you want to get information by email?** ☐ **Yes** ☐ **No** If Yes, provide your email address below.<br>**Email:** _____ |
| **12** | **Do you work?** ☐ **Yes** ☐ **No** **Does your spouse work?** ☐ **Yes** ☐ **No** ☐ Does not apply |
| **13** | **Name of the primary care clinic/care system you are choosing:** |

**Section 3. Tell us about your Medicare and Medical Assistance coverage:**

Fill in your Medicare and Minnesota Health Care Program (MHCP) information below. You can find Medicare information on your red, white, and blue Medicare card or in a letter from Social Security or the Railroad Retirement Board. Also, please put your Minnesota Health Care Program (MHCP) Member Number as it appears on the front of your card. This is also known as your Medical Assistance Member Number.

| | | |
|---|---|---|
| **14** | **Medicare Number:**_____ | **MHCP Member Number:** _____ |

**Section 4. Tell us about your health coverage including your prescription drug coverage:**

Some people have other health insurance or drug coverage through private insurance, TRICARE, Employers, Unions, Veterans Affairs, or the State Pharmaceutical Assistance Programs.

| | | |
|---|---|---|
| **15** | **Do you have other health coverage?** ☐ **Yes** ☐ **No** If Yes, fill in the information below: | |
| **16** | **Name of your plan (and employer, if applicable):** | **Group number:** |
| | | **Policy or ID number:** |

If you have health coverage from an employer or union right now, you or your dependents could lose that coverage when you join AbilityCare. Your employer or union can give you more information about your coverage. If you have questions, talk with the person in your office who takes care of benefits.

Member Name: _____ MHCP Member Number: _____

**Section 5. Tell us about your enrollment eligibility.**

Please read the following statements carefully and check the box if the statement applies to you. **Check all that apply**. 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 applying during the Medicare Advantage plan annual enrollment period from October 15 through December 7 and want my enrollment effective January 1.

☐ I am new to Medicare.

☐ I have both Medicare and Medical Assistance (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I have Medicare and get full Medical Assistance benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medical Assistance managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).

☐ I recently had a change in my Medical Assistance (newly got Medical Assistance or had a change in level of Medical Assistance) on (date) _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (date) _____.

☐ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home). I moved or will move into or out of the facility on (date) _____.

☐ I recently moved outside of the service area for my current plan, or I recently moved and have new options available to me. I moved on (date) _____.

☐ I am leaving employer or union coverage on (date) _____.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (date) _____.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state), and I want to choose a different plan. My enrollment in that plan started on (date) _____.

☐ I recently was released from incarceration. I was released on (date) _____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (date) _____.

☐ I recently obtained lawful presence status in the United States. I got this status on (date) _____.

☐ I was affected by a weather-related emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, State, or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements apply to you or you're not sure, please contact AbilityCare at 1-866-567-7242 (TTY users should call 1-800-627-3529 or 711) to find out if you're eligible to enroll. We are open 7 days a week, 8 a.m. - 8 p.m. (October - March) ; Monday - Friday, 8 a.m. - 8 p.m.(April - September).

**Information and Acknowledgement Statements**

- My response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I must keep Medicare Part A and Part B and Medical Assistance to stay in AbilityCare.
- 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).
- By joining AbilityCare, I acknowledge that the 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 collection of this information (refer to the Privacy Act Statement below).
- I understand that when my AbilityCare coverage begins, I must get my medical and prescription drug benefits from AbilityCare.
- Benefits and services provided by AbilityCare and contained in my *Member Handbook* are covered. Neither Medicare nor AbilityCare will pay for benefits or services that are not covered.
- I understand that AbilityCare doesn't usually cover people while they're out of the country except under limited circumstances.
- I can choose to leave AbilityCare any month of the year. I understand my Medical Assistance will be provided fee-for-service. I understand I can re-enroll in the non-integrated SNBC plan I was enrolled in before AbilityCare by filling out a new enrollment form.
- If I get a medical spenddown while enrolled in AbilityCare and do not pay it to the State, I will be disenrolled from AbilityCare.
- 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 my authorized representative's signature) on this form means that I've read and understood this form. If an authorized representative signs, this signature means 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 and/or Medical Assistance.

Member Name: _____ MHCP Member Number: _____

**Please read the information on pages 3 and 4 and sign below.**

When you sign this form, it means that you understand the information you read.

_____
Name of Applicant (Please print)

_____ _____
Signature Today's Date

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

_____ _____
Name (Print) Relationship to Enrollee

_____ _____
Address + City, State, Zip (Print) Telephone Number

**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): _____

## When the form is complete, mail or fax pages 1 to 5 to South Country Health Alliance. Our address and fax number are on the cover.

### 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 and 422.60 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.