To Enroll in Health Alliance Medicare, Please Provide the Following Information:

<table>
<thead>
<tr>
<th>Desired Effective Date (must be in the future, not more than 60 days out):</th>
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<tbody>
<tr>
<td>Employer or Union name:</td>
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Please choose the one plan you are enrolling in from the options below:

- HMO Option 1
- POS Option 1
- HMO 20 Rx
- POS 10 Rx
- HMO Option 2
- POS Option 2
- HMO 40 Rx
- POS 30 Rx
- HMO Basic
- POS Option 3
- POS Basic
- POS Basic Rx
- PDP Option 1
- POS Basic Rx
- PDP Option 2

Other: ______________________________________________________________________


- Simplete 1 (HMO)
- Simplete 2 (HMO)
- Simplete 3 (POS)

These plans are available to you if you live in one of the counties listed: Grundy, Iroquois, Kankakee and Livingston counties in Illinois and Benton and Newton counties in Indiana.

- Simplete Riverside 2 (HMO)
- Simplete Riverside 3 (POS)

These plans are available to you if you live in one of the counties listed: Iroquois and Kankakee counties in Illinois.

- Simplete Riverside 1 (HMO)

These plans are available to you if you live in one of the counties listed: Boone, Bureau, DeWitt, Henderson, Henry, Knox, LaSalle, Livingston, Marshall, McLean, Peoria, Putnam, Stark, Tazewell, Warren, Winnebago and Woodford counties in Illinois.

- OSF MedAdvantage Open (POS)
- OSF MedAdvantage Plus (POS)
- OSF MedAdvantage Core (HMO)
- OSF MedAdvantage Select (HMO)
Please read and answer these important questions:

1. Are you the retiree?  Yes ☐   No ☐
   If yes, retirement date (month/date/year): _________________________
   If no, name of the retiree: ____________________

2. Are you enrolled in your State Medicaid program?  Yes ☐   No ☐
   If yes, please provide your Medicaid number: ________________________________________

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 Health Alliance Medicare?  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:  Group # for this coverage:

Please Provide Your Medicare Insurance Information:

Please take out your red, white and blue Medicare card to complete this section.

- OR -

- Fill out this information as it appears on your Medicare card.

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Please read and answer these important questions:
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 check one of the boxes below if you would prefer that we send you information in a
language other than English or in another format:  □ Spanish   □ Large print

Please contact Health Alliance Medicare at 1-800-965-4022 if you need information in another
format or language than what is listed above. Our office hours are Monday through Friday, 8 a.m. to
8 p.m. TTY users should call 711.

Please Read and Sign on Next Page

By completing this enrollment application, I agree to the following:
Health Alliance Medicare is a Medicare Advantage plan and a Medicare drug plan and has a contract
with the Federal government. I will need to keep my Medicare Parts A and B (or Part A or B for PDP).
I can be in only one Medicare Advantage or PDP 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 you of any prescription drug coverage that I have or may get in the future. I understand that
if I don’t have Medicare prescription drug coverage, or creditable prescription drug coverage (as good
as Medicare’s), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug
coverage 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 (Example:
Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

Health Alliance Medicare serves a specific service area. If I move out of the area that Health Alliance
Medicare serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once
I am a member of Health Alliance Medicare, I have the right to appeal plan decisions about payment
or services if I disagree. I will read the Evidence of Coverage document from Health Alliance Medicare
when I get it to know which 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.

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

For PDP only: I understand that I must use network pharmacies except in an emergency when I cannot
reasonably use Health Alliance Medicare Stand-Alone Prescription Drug Plan network pharmacies.
Once I am a member of Health Alliance Medicare Stand-Alone Prescription Drug Plan, I have the right
to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage
document from Health Alliance Medicare Stand-Alone Prescription Drug Plan when I get it to know
which rules I must follow to get coverage.

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

Counseling services may be available in my state to provide advice concerning Medicare Supplement
insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance
through the state Medicaid program and the Medicare Savings Program.
Release of Information: By joining this Medicare health plan, I acknowledge that Health Alliance Medicare will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Alliance Medicare 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 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 by Health Alliance Medicare or by Medicare.

To Complete the Application, Please Sign

Signature: [Signature] Today’s Date: [Today’s Date]

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

Name: [Name]

Address: [Address]

Phone Number (____) _____ - ______

Relationship to Enrollee: ____________________________
Health Alliance complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Health Alliance does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Health Alliance:

- 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 (large print audio, accessible electronic formats, 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 service.

If you believe that Health Alliance 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: Health Alliance Medicare, Member Services, 3310 Fields South Drive, Champaign, IL 61822 or 411 N. Chelan Avenue, Wenatchee, WA 98801, telephone for members in Illinois, Indiana, Iowa and Ohio: 1-800-965-4022; telephone for members in Washington: 1-877-750-3350 TTY: 711, fax: 217-902-9705, MemberServices@healthalliance.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Member Services is available to help you. 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, TTY: 1-877-750-3350.


ATENCIÓN: Si habla Español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. IA, IL, IN, OH: Llame 1-800-965-4022; WA Llame: 1-877-750-3350 (TTY: 711).


ƯU ĐÀM: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. IA, IL, IN, OH: Gọi 1-800-965-4022, WA: Gọi 1-877-750-3350 (TTY: 711).


 Sentinel: Ads à la langue arabe, une aide est disponible pour vous. IA, IL, IN, OH: Appelez 1-800-965-4022, WA: Appelez 1-877-750-3350 (TTY: 711).


ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. IA, IL, IN, OH: Appelez 1-800-965-4022, WA: Appelez 1-877-750-3350 (TTY: 711).

चैय सुबिंध आई. तान्याच्या सहयोगास संवादांचे, मुक्त, तमाख भाव उपलब्ध आहे. IA, IL, IN, OH: कॉल 1-800-965-4022, WA: कॉल 1-877-750-3350 (TTY: 711).

注意: あなたは、日本語, 免料で言語支援サービスを、話す場合は、あなたに利用可能です。1-800-965-4022 IA, IL, IN, OH: コール 1-877-750-3350 WA: コール (TTY: 711)。

LET OP: Als je spreekt pennsylvaniaanse nederlandse, taalkundige bijstand diensten, gratis voor u beschikbaar zijn. IA, IL, IN, OH: Bel 1-800-965-4022, WA: Bel 1-877-750-3350 (TTY: 711).


ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. IA, IL, IN, OH: Chiamare 1-800-965-4022, WA: Chiamare 1-877-750-3350 (TTY: 711).

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