Select Health

Enrollment Request Form

NEVADA 2027

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 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?

Send your completed and signed form to:

Select Health Medicare
PO Box 30196
SLC, Utah 84130-0196
or FAX **1 855-442-0357**

Once we process your request to join, we will notify you.

How do I get help with this form?

Call Select Health at **855-442-9940**, TTY users can call **866-506-6005**. Or, call Medicare at **800-MEDICARE (800-633-4227**). **TTY** users, please call **877-486-2048**.

En español: Llame a Select Health al **855-442-9940 (TTY: 866-506-6005)** o a Medicare gratis al **800-633-4227 (TTY: 711)** y oprima el 2 para asistencia enespañol 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.

If you have questions, call us: **Toll-free 855-442-9940** (**TTY: 866-506-6005**)

October 1 to March 31
Weekdays: 8:00 a.m. to 8:00 p.m.
Weekends: 8:00 a.m. to 8:00 p.m.

April 1 to September 30
Weekdays: 8:00 a.m. to 8:00 p.m.
Weekends: Closed

OMB No. 0938-1378 Expires: 02/28/2029

Select Health is an HMO, SNP plan sponsor with a Medicare contract. Enrollment in Select Health Medicare depends on contract renewal.

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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this form to send your completed form to the plan.

Select Health

P.O. Box 30196, Salt Lake City, UT 84130-0196
Fax: **855-442-0357** | **selecthealth.org/medicare**

Select Health Medicare Enrollment Request Form **NEVADA**

SECTION 1 – All fields on this page are required (unless marked optional)	
Select the plan you want to join:	
☐ **Select Health Medicare Essential (HMO) 012** Clark and Nye counties.	**$0/month**
☐ **Select Health Medicare Value Giveback (HMO) 021** Clark and Nye counties.	**$0/month**
☐ **Select Health Medicare Wellness (HMO) 044** Clark and Nye counties.	**$0/month**
☐ **Select Health Medicare Veterans (HMO) 046** Clark and Nye counties.	**$0/month**

FIRST name:	LAST name:	[Optional: Middle Initial]:
Birth date: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Sex: ☐ Male ☐ Female	Phone number: ( )

☐ I agree to receive calls and/or text notifications from Select Health regarding plan information, benefits, and other account related communications. Message frequency varies and text and data rates may apply. You may opt out of text messages at any time by replying STOP.

Permanent Residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:	[Optional: County]:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):

Street address: City: State: ZIP Code:

YOUR MEDICARE INFORMATION:

Medicare Beneficiary Identification Number: _ _ _ _ - _ _ _ - _ _ _ _

ANSWER THESE IMPORTANT QUESTIONS:

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

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

_____ _____ _____

Applicant First and Last Name: _____

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

IMPORTANT: READ AND SIGN BELOW

I must keep both Hospital (Part A) and Medical (Part B) to stay on Select Health Medicare.

By joining this Medicare Advantage, I acknowledge that Select Health Medicare 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 on second page). 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 (exception apply for MA PFFS, MA MSA plans).

I understand that when my Select Health Medicare coverage begins, I must get all my medical and prescription drug benefits from Select Health Medicare. Benefits and services provided by Select Health Medicare and contained in my Select Health Medicare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Select Health Medicare will pay for benefits or services that are not covered.

Enrollment in the Select Health Medicare Veterans plan does not include Part D prescription drug coverage. Members may receive prescription drug coverage through the VA or another source of creditable coverage. Members who do not maintain creditable prescription drug coverage may be subject to a late enrollment penalty if they enroll in a Part D plan in the future.

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.

Signature: **Today's date:**

_____ / _____ /_____

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

Name: _____

Address: _____

Phone number: (_____) _____ -_____

Relationship to Enrollee: _____

Applicant First and Last Name: _____

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SECTION 2: ALL FIELDS IN THIS SECTION ARE OPTIONAL
Answering these questions is your choice. You can't be denied coverage if you don't fill them out.

This information is available for free in other languages (e.g. Spanish) and alternate formats (e.g. audio, braille) upon request. Please contact Select Health Medicare for assistance at **855-442-9940** (TTY: **866-506-6005**). Our office hours are Monday through Friday, 7:00 a.m. to 8:00 p.m. and Saturday, 9:00 a.m. to 2:00 p.m. We are closed on Sundays.

ELECTION PERIOD (Optional)

Check one:

☐ AEP (Annual Enrollment Period) October 15 to December 7 of every year

☐ ICEP (Initial Coverage Election Period) When you're first eligible for Medicare

☐ SEP (Special Enrollment Period) **SEP Circumstance #** _____

Requested Date of Coverage _____ / _____ /_____

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

PRIMARY CARE PROVIDER

List your Primary Care Physician (PCP), clinic, or health center:

☐ I have a Primary Care Provider.

PCP Name (e.g., Dr. Jerome Smith or Nurse Practitioner Kay Harley)

_____

What is your PCP's address? (The name and address of the clinic or office)

_____

☐ I don't have a Primary Care Provider.

An in-network PCP is recommended on our HMO plan to help coordinate your care and assist with referrals. If you do not have a PCP, or your current PCP is out of network, one will be assigned whose practice is near your home. You can change your PCP at any time by updating your member account or contacting the plan.

Need help finding a PCP or checking if your current doctor is in our network?
Visit **selecthealth.org/find-care** or call us at **855-422-9900** (**TTY 711**).

EMAIL OPT-IN

Email address _____

☐ Go paperless

By going paperless, you consent to the electronic distribution of materials related to your coverage and select communications which will be printed and mailed. Paperless terms and conditions can be reviewed at any time in the Select Health Medicare member account.

When you give us your email address, you agree to get messages about your coverage by email once you are a member. To view your personal documents, messages, and contract online, you'll need to create a Select Health Medicare member account at **selecthealth.org/get-started** once your coverage starts.

The provided email address and communication preferences can be updated anytime in the Select Health Medicare member account.

Applicant First and Last Name: _____

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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: _____ Signature: _____ Relationship to enrollee: _____ National Producer Number (Agents/Brokers only): _____

Applicant First and Last Name: _____

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Pre-Enrollment Checklist

Understanding the Benefits:

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. If you have questions, you can call and speak to a representative at the number listed in this guide.
- Review the provider directory, or ask your doctor, to make sure the doctors you see are in the network. If they are not listed, you will likely have to select new doctors.
- Review the Pharmacy Directory to make sure your pharmacy is in the network. If it isn't, you may need to choose a new one.
- Review the plan formulary, which is a list of generic and brand-name prescription drugs covered by the health plan. The formulary also reviews the different tiers of the drug plan, the drugs that fall within each tier, and your cost.

Understanding Important Rules:

- In addition to your monthly plan premium (if you have one), you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums, copayments, and coinsurance are your out-of-pocket costs and may vary by plan. These amounts apply to the 2027 plan year and may change on January 1, 2028.
- Except in emergency or urgent situations, we do not cover services performed by out-of-network providers (doctors who are not listed in the provider directory).

Understanding the Effect on Current Coverage:

- If you are currently enrolled in a Medicare Advantage plan, your current health coverage will end once your new Medicare Advantage plan coverage starts.
- If you're currently enrolled in Original Medicare, your Medicare Advantage coverage will begin on the first day of the month indicated in your enrollment. To avoid any disruption in your care, be sure to start using your new Medicare Advantage card for all services received after your coverage start date.
- If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact your sales agent or Tricare for more information.
- If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap plan because you will be paying for coverage you cannot use.
- If you have Employer Group coverage, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact your employer or your sales agent for more information.

Before making an enrollment decision, it's important that you fully understand our benefits and rules.

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Notice of Nondiscrimination

Select Health obeys Federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, veteran status, and/or any other characteristic protected by applicable federal or state law.

We provide free:

- Aid to those with disabilities to help them talk with us. This may be sign language interpreters or info in other formats (large print, audio, electronic).
- Help for those whose first language is not English, such as interpreters or member materials in other languages.

Need help? Call:

- Select Health Member Services: **1-800-538-5038 (TTY: 711)**
- Select Health Medicare Member Services: **1-855-442-9900 (TTY: 711)**
- Select Health Medicaid Member Services: **1-855-442-3234 (TTY: 711)**
- Select Health FEHB Member Services: **1-844-345-3342 (TTY: 711)**

If you feel you've been treated unfairly, you can reach the Select Health 504/Civil Rights Coordinator by:

Phone: **1-844-208-9012 (TTY Users: 711)**; Compliance Hotline: **1-800-442-4845**

Mail: Select Health (Attn: Civil Rights Coordinator)
5381 South Green Street
Murray, UT 84123

Email: **ContactCompliance@imail.org**

You may also contact the Office for Civil Rights at:

Online: **ocrportal.hhs.gov/ocr/smartscreen/main.jsf**

Phone: **1-800-368-1019**; TTY Users: **1-800-537-7697**

Mail: U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F,
HHH Building, Washington, D.C. 20201

HHS complaint forms are available at: **hhs.gov/ocr/complaints/index.html**

This notice is available at: **selecthealth.org/disclaimers/non-discrimination**

Notice of Availability

ATTENTION: We provide free language assistance services. We also offer free auxiliary aids and services when needed. Call **1-800-538-5038 (TTY Users: 711)**.

ATENCIÓN: Ofrecemos servicios gratuitos de asistencia con el idioma. También brindamos servicios y ayudas auxiliares gratuitos cuando los necesite. Llame a Select Health.

注意：我們提供免費的語言協助服務。如有需要，我們也免費提供輔助工具及服務。請致電 Select Health。

CHÚ Ý: Chúng tôi cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí. Chúng tôi cũng cung cấp miễn phí các phương tiện và dịch vụ hỗ trợ bổ sung khi cần. Gọi Select Health.

알림: 저희는 무료 언어 지원 서비스와 필요한 경우 무료 보조 장비 및 서비스를 제공하고 있습니다. Select Health로 전화해 주십시오.

ध्यान दिनुहोस्: हामी भाषासम्बन्धी सहायता सेवा निःशुल्क रूपमा प्रदान गर्छौं। आवश्यक परेमा निःशुल्क सहायक सामग्री तथा सेवाहरू पनि उपलब्ध गराउँछौं। *Select Health* मा फोन गर्नुहोस्।

PAUNAWA: Nagbibigay kami ng mga serbisyo ng tulong sa wika nang walang bayad. Nag-aalok din kami ng mga karagdagang tulong at serbisyo (auxiliary aids) nang walang bayad kung kinakailangan. Tumawag sa Select Health.

ACHTUNG: Wir bieten kostenlose Sprachunterstützung an. Bei Bedarf stellen wir Ihnen auch kostenlose Hilfsmittel und Dienstleistungen zur Verfügung. Rufen Sie Select Health an.

ВНИМАНИЕ. Мы предоставляем бесплатные услуги языковой поддержки. При необходимости мы также предлагаем бесплатные вспомогательные средства и услуги. Позвоните в Select Health.

ATTENTION : Nous fournissons des services d'assistance linguistique gratuits. Nous offrons également des aides et services auxiliaires gratuits en cas de besoin. Appelez Select Health.

注意事項：無料の言語支援サービスを提供しています。また、必要に応じて無料の補助的手段やサービスも提供しています。Select Healthまでお電話ください。

ማሳሰቢያ፦ ነጻ የቋንቋ ድጋፍ አገልግሎቶች እናቀርባለን። እንዲሁም አስፈላጊ ሲሆን ነጻ የተግባቦት መርጃ መሣሪያዎችን እና አገልግሎቶችን እናቀርባለን። ወደ Select Health ይደውሉ።

ПАЖЊА: Ако говорите српски, бићe вам доступне бесплатне услуге језичке подршке. Такође пружамо бесплатна помоћна средства и услуге када су потребни. Контактирајте Select Health.

تنبيه: نقدم خدمات المساعدة اللغوية مجانًا. كما نوفر وسائل وخدمات مساعدة مجانية عند الحاجة. يُرجى الاتصال بـ Select Health.

توجه: ما خدمات رایگان کمک زبانی ارائه می‌کنیم. همچنین، در صورت نیاز، خدمات و تجهیزات کمکی رایگان ارائه می‌دهیم. با Select Health تماس بگیرید.

โปรดทราบ: เราให้บริการช่วยเหลือด้านภาษาฟรี นอกจากนี้เรายังมีบริการและอุปกรณ์ช่วยเหลือเพิ่มเติมฟรีเมื่อจำเป็น โทรติดต่อ Select Health

Select Health: 1-800-538-5038 (TTY Users: 711)

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