HealthSpring℠

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# 2026 Medicare Prescription Drug Plan Individual Enrollment Form

## Who can use this form?

People with Medicare who want to join a Medicare Prescription Drug Plan

**To join a plan, you must:**

- Be a United States citizen or be lawfully present in the United States.
- Live in the plan's service area

**Important:** To join a Medicare Prescription Drug Plan, you must also have either or 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 and December 7 each year (for coverage starting January 1)
- Within three 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 residence street address (P.O. Box is not allowed unless you are experiencing homelessness) 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.
- We 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
**HealthSpring Medicare Prescription Drug Plans**
**P.O. Box 269005**
**Weston, FL 33326-9927**

Or fax it to this number: **1-800-735-1469**.

Once we process your request to enroll, we will contact you.

Call HealthSpring at **1-877-534-0199**.
TTY users can call 711.

## How do I get help with this form?

Or call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users can call 1-877-486-2048.

En español: Llame a HealthSpring al **1-877-534-0199**/ 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 P.O. 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.

HealthSpring

# HealthSpring Medicare Prescription Drug Plan 2026 Enrollment Form

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

**To enroll in a HealthSpring Medicare Prescription Drug Plan, please provide the following information:**

**Please check which plan you want to enroll in:** ☐ **HealthSpring Extra Rx (PDP)** ☐ **HealthSpring Assurance Rx (PDP)**

| LAST Name: | FIRST Name: | Middle Initial: | ☐ Mr. ☐ Mrs. ☐ Ms. |
|---|---|---|---|

Birth Date: (__ __ / __ __ / __ __ __ __) (M M / D D / Y Y Y Y)

Sex: ☐ M ☐ F

Phone numbers to contact you:

Primary number (__ __ __) __ __ __ - __ __ __ __ ☐ Home ☐ Cell

Alternate number (optional) (__ __ __) __ __ __ - __ __ __ __ ☐ Home ☐ Cell

By providing my phone number, I agree to receive calls, texts or emails from Health Care Service Corporation, its subsidiaries and affiliates regarding the administration of my HealthSpring plan benefits and services. Calls may be autodialed or prerecorded. You can opt out at any time.

To receive email communications provide your email address below. To update your communication preferences visit **myHealthSpring.com**

Your Email Address (optional):

Permanent Residence Street Address (P.O. Box is not allowed unless you are experiencing homelessness):

| City: | State: | ZIP Code: |
|---|---|---|

Mailing Address (only if different from your Permanent Residence Address):

Street Address: _____ City: _____ State: _____ ZIP Code: _____

Emergency Contact (optional): Phone Number: Relationship to You:

**Please provide your Medicare insurance information:**

Medicare number: _____

**Answer these important questions:**

Will you have other prescription drug coverage (like VA, TRICARE) in addition to HealthSpring Medicare Prescription Drug Plan? ☐ Yes ☐ No

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

**IMPORTANT: Read and sign below**

- I must keep Hospital (Part A) or Medical (Part B) to stay in HealthSpring Medicare Prescription Drug Plan.
- By joining this Medicare Prescription Drug Plan, I acknowledge that HealthSpring will share my information with Medicare, who may use it to track my enrollment, to make payments, and other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- 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 (exceptions apply for MA PFFS, MA MSA plans).
- 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.
- HealthSpring Medicare Prescription Drug Plan serves a specific service area. If I move out of the area that HealthSpring Medicare Prescription Drug Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies, except in an emergency when I cannot reasonably use HealthSpring Medicare Prescription Plan network pharmacies.
- 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.

By providing my phone number and signing below, I agree to receive calls and texts from Health Care Service Corporation (HCSC), its subsidiaries, affiliates and brokers regarding additional HealthSpring products or services. I acknowledge these calls may be autodialed or prerecorded and use an artificial or prerecorded voice. I agree that HCSC may use the information provided or obtained in connection with this application, or insurance coverage provided by HCSC including my personal information, to offer me additional products and services or to send related marketing communications regarding HealthSpring products. I acknowledge that I am not required to provide consent to receive these communications as a condition of applying for coverage. If I choose not to receive marketing communications, I will indicate that by checking the box below or I can withdraw my consent at any time by contacting HealthSpring.

☐ I do not consent to receive marketing communications at the phone number provided.

| **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 _____

**Special Enrollment Period**
**Skip this section if you are enrolling between October 15 – December 7**

**Please complete** – if you are enrolling outside of October 15 – December 7.

**Typically, you may enroll in a Medicare Prescription Drug Plan only during the Annual Enrollment Period from October 15 through December 7 of each year.** Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the Annual Enrollment Period.

Please read the following statements carefully and check the box if the statement applies to you. 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 new to Medicare.
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I have Medicare and Medicaid, or I get Extra Help paying for Medicare drug costs. I want to switch to a different Medicare drug plan.
- ☐ I live in or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I recently left a PACE program on (insert date) _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ☐ I am leaving employer or union coverage on (insert date) _____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly received, had a change, or lost Extra Help) on (insert date) _____.
- ☐ 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 (insert date) _____.
- ☐ I recently had a change in my Medicaid (newly received, had a change, or lost Medicaid) on (insert date) _____.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (January 1 – March 31)
- ☐ I recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently obtained lawful presence status in the U.S. I got this status on (insert date) _____.
- ☐ I was affected by an 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 request because of the disaster.

If none of these statements applies to you or you're not sure, please contact HealthSpring Medicare Prescription Drug Plan at **1-877-534-0199 (TTY 711)** to see if you are eligible to enroll. We are open 8 a.m. – 8 p.m. local time, 7 days a week. Our automated phone system may answer your call during weekends from April 1 – September 30.

## Section 2 – All fields that follow below are optional

Answering these questions is your choice. You can't be denied coverage because you didn't fill them out.

**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 ☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Please contact HealthSpring Medicare Prescription Drug Plan at **1-877-534-0199** if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. – 8 p.m. local time, 7 days a week. Our automated phone system may answer your call during weekends from April 1 – September 30. TTY users can call 711.

### Paying your plan premium:

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail, Electronic Funds Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit 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 or Railroad Retirement Board benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to HealthSpring Medicare Prescription Drug Plan.

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

**Please select a premium payment option:**

☐ Receive a bill

☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board (RRB) benefit check. (Depending on the date your enrollment is processed, you may receive a premium invoice for the first month you are enrolled. If Social Security/Railroad Retirement Board accepts your request for deduction, the deduction from your benefit check may take several months to take effect. Therefore, your first deduction may include the premiums for several months. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

**I get monthly benefits from:** ☐ **Social Security** ☐ **RRB**

After Medicare has approved your enrollment, you will have additional payment options to choose from. Visit **HealthSpring.com/pay-my-premium** for online payment options and details.

## For individuals helping enrollee with completing this form only

Complete this section if you're an individual helping an enrollee fill out this form (for example: SHIP counselor, family member, or other third party).

Name: _____ Signature: _____

Relationship to enrollee: _____

## Producer Use Only:

The person that is discussing plan options with you is either employed by or contracted directly or indirectly with HealthSpring. The person may be compensated based on your enrollment in a plan.

Requested Effective Date: _____

☐ IEP ☐ AEP ☐ SEP (See Special Enrollment Period Section)

Name of Plan Representative/Agent/Broker: _____

Producer Last Name: _____ Producer First Name: _____

National Producer Number: _____

Producer Agency: _____

Producer must provide how the enrollment was completed:

☐ Face-to-face meeting ☐ Walk-in ☐ Sales event ☐ Through mail ☐ Telephone

Producer Signature: _____

Producer Phone: (__ __ __) __ __ __ - __ __ __ __ Producer E-mail: _____

**Producer needs to provide Effective Date requested, IEP, AEP, or SEP information above. Please be sure to sign the form and provide your National Producer Number.**

### 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 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.