2026 MEDICARE ADVANTAGE

INDIVIDUAL ENROLLMENT FORM

Who can use this form?
People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug 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 January1)
- Within 3 months of first getting Medicare
- In certain situations where you are 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 cannot be denied coverage because you do not 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.
- If you are eligible for an I-SNP or IE-SNP Institutional Equivalent, you may qualify for a Special Enrollment Period and can enroll year-round.
- 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:

- Abilis Health Plan
  805 N Whittington Parkway
  Louisville, Kentucky 40222
- Fax to 1-800-880-3263

Once they process your request to join, they will contact you.

How do I get help with this form?

Call Abilis Health Plan at 1-844-214-8633 (TTY 711).

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

En Español: Llame a Abilis Health Plan al 1-844-214-8633/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 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.

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

Select the Plan you want to join:

☐ Abilis Health Plan
$35.90 per month

☐ Abilis Community Health Plan
$0.00 per month

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

Birth date: (MM / DD / YYYY)	Sex:	Phone Number:
(/ /)	☐ Male ☐ Female	( )

Permanent Residence Street Address (Do Not Enter PO Box):

City:	County:	State:	Zip Code:

Mailing Address - If different from your Permanent Residence Address (PO Box Allowed):

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

Your Medicare Information:

Medicare Number: _____

Answer These Important Questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Abilis Health Plan?

☐ Yes ☐ No	Name of other Coverage:	Member number for this coverage:	Group number for this Coverage:

Are you a resident in a long-term care facility, such as a nursing home or assisted living facility? ☐ Yes ☐ No

If Yes – Please provide Facility Name: _____

Facility Address: _____

Are you enrolled in your State Medicaid program? Yes ☐ No ☐

If yes, please provide your Medicaid number: _____

IMPORTANT: Read and Sign Below

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Abilis Health Plan (formerly Signature Advantage Plan; transition effective January 1, 2026), he/she may be paid based on my enrollment in Abilis Health Plan (previously Signature Advantage Plan).

- I must keep both Hospital (Part A) and Medical (Part B) to stay enrolled with Abilis Health Plan.
- By joining this Medicare Advantage, I acknowledge that Abilis Health 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 the collection of this information (see Privacy Act Statement on last 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 (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Abilis Health Plan coverage begins, I must get all my medical and prescription drug benefits from Abilis Health Plan. Benefits and services provided by Abilis Health Plan and contained in my Abilis Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Abilis Health Plan will pay for benefits or services that are not covered.
- 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**:

Authorized Representatives: Sign and Date Above **and** Fill Out Below

Name:	Address:
Phone Number:	Relationship To Enrollee:

SECTION 2 – All fields are optional in Section 2

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

Select One – If you would like us to send you information in a language other than English.

- ☐ Español (Spanish)
- ☐ Other _____

Select One – If you would like us to send you information in an accessible format.

- ☐ Braille
- ☐ Large Print
- ☐ Audio CD
- ☐ **Other** – Please contact Abilis Health Plan at 1-844-214-8633; TTY 711, if you need information in an accessible format other than what is listed above. **Hours of Operation:** 8 a.m. to 8 p.m., 7 days a week from October 1 through March 31, and 8 a.m. to 8 p.m., Monday through Friday from April 1 through September 30 (excluding Thanksgiving & Christmas Day and Federal holidays).

Are You Currently Working?	Is Your Spouse Currently Working?
☐ Yes ☐ No	☐ Yes ☐ No

Please list the name of your Primary Care Physician (PCP), clinic, or health center:

I would like to receive the following materials via email:

☐ **Enrollment Communications** (relevant enrollment correspondence, including signed copies of this form)

Please Provide your E-mail Address: _____

Paying Your Plan Premiums

- You can pay your monthly plan premium (including any late enrollment penalties that you currently have or may owe) by mail each month.
- **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**
- **If you are required 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.** DO NOT send your Part D-IRMAA payment to us. This amount is collected by Medicare, not by Abilis Health Plan.

Continued next page

Paying Your Plan Premiums *(Continued)*

Please select a premium payment option below: If no option is selected, you will receive a monthly bill by default.

☐ **Deduct From My Social Security or Railroad Retirement Board (RRB) benefit** **

- I receive monthly benefits from: _____ Social Security _____ RRB

☐ **Send me a Monthly Bill**

I will receive a monthly premium bill and pay directly to Abilis Health Plan, by mail before the due date on bill. (***Note:*** *If you choose this option, you are responsible for making sure your monthly premium is paid on time. Late or missed payments may result in loss of coverage*.)

**The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If social Security RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

OFFICE USE ONLY

Complete this section if you're an individual helping an enrollee fill out this form
Such as agents, brokers, SHIP counselors, family members, or other third parties

Abilis Account Executive Name
(if assisted with enrollment): _____

Agent / Broker Name & **National Producer Number** (if assisted with enrollment): _____

Effective Date of Coverage: _____

Plan ID #: _____

☐ ICEP / IEP
☐ AEP
☐ SEP (type) _____
☐ Not Eligible
☐ Other

Date Received by Abilis Health Plan: _____ / _____ / _____

Abilis Health Plan (HMO FI-SNP) and Abilis Health Community Plan (HMO IE-SNP) "Abilis Health Plan", offered by Signature Advantage Plan, LLC, are a Health Maintenance Organization Special Needs Plan (FI-SNP / IE-SNP) with a Medicare contract. Enrollment in Abilis Health Plan 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 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.