Align DUALPartnership Plan
2025 Individual Enrollment Form

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 be enrolled in both:

- Medicare Part A (Hospital insurance)
- Medicare Part B (Medical insurance)

When do I use this form?

You can join a plan:

- Between Oct. 15–Dec. 7 each year (for coverage starting Jan. 1)
- Within three months of first joining Medicare
- In certain situations that allow you 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 if you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (Oct. 15–Dec. 7), you must submit your completed form by Dec. 7.
- You can choose to receive a bill for your plan's premium. Or, you can choose to sign up to have your premium payments deducted from your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Sanford Health Plan
P.O. Box 91110
Sioux Falls SD 57109

You'll be contacted once your request has been processed.

How do I get help with this form?

Call Sanford Health Plan at (888) 605-9277. TTY users can call 711.

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

En español: Llame a Sanford Health Plan al (888) 605-9277/TTY 711 o a Medicare gratis al (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 with the monthly premium you prefer:

☐ Align DualPartnership (2025 North Dakota) – $46.90

Your personal information

First name:	Last name:	Middle initial (optional):
Birth date (mm/dd/yyyy):	Sex: ☐ M ☐ F	Phone number:

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:	County:	State:	ZIP Code:

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

City:	State:	ZIP Code:

Email address (optional): (By providing your e-mail address, you are agreeing to receive electronic communications from Sanford Health Plan.)

Your Medicare information

Medicare number:

___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Answer these important questions

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

☐ Yes ☐ No

Name of other coverage: _____

Member number for this coverage: _____

Group number for this coverage: _____

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

If yes, please provide your Medicaid number: _____

Eligibility for an Enrollment Period: Please check the box that applies to you. (optional)

In order to join this plan, you must be eligible for Medicaid through the State of North Dakota. You may have received a Medicaid ID card in addition to your Medicare ID card or you may have heard terms like Qualified Medicare Beneficiary (QMB), Qualified Medicare Beneficiary Plus (QMB+), Special Low-Income Medicare Beneficiary Plus (SLMB+), other Full Benefit Dual Eligible (other FBDE).

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.

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Eligibility for an Enrollment Period (continued)

- ☐ I am new to Medicare.
- ☐ I already have hospital (Part A) and recently signed up for Medical (Part B). I want to join a Medicare Advantage Plan.
- ☐ I'm new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started. (Date of Medicare Entitlement Letter) _____ .
- ☐ I had Medicare prior to now, but I'm now turning 65.
- ☐ Between 1/1 and 3/31: I'm in a Medicare Advantage Plan and want to make a change.
- ☐ Between 4/1 and 12/31: I'm in a Medicare Advantage Plan and have had Medicare for less than three months. I want to make a change.
- ☐ 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 was released from incarceration. I was released 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 recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ☐ I recently had a change in my Medicaid (recently joined Medicaid, had a change in the level of Medicaid assistance or lost Medicaid) on (insert date) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (recently got Extra Help, had a change in the level of Extra Help or lost Extra Help) on (insert date) _____.
- ☐ I have both Medicare and Medicaid (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 live in a long-term care facility, like a nursing home or a rehabilitation hospital.
- ☐ I recently moved out of a long-term care facility, like a nursing home or a rehabilitation hospital. I moved 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 (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 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 was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

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Eligibility for an Enrollment Period (continued)

☐ 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.

☐ I'm in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan. My plan went into receivership on (insert date) _____.

☐ I'm in a plan that's had a star rating of less than 3 stars for the last 3 years. I want to join a plan with a star rating of 3 stars or higher.

☐ Other

If none of these statements applies to you, or you're not sure, please contact Sanford Health Plan at (888) 605-9277 (TTY: 711) to see if you are eligible to enroll. We are open from 8 a.m. to 8 p.m. local time, Monday through Friday.

IMPORTANT: Read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) coverage to stay enrolled in Align DUALPartnership.
- By joining this Medicare Advantage Plan, I acknowledge that Sanford 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 laws that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- 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 dis-enrolled 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.
- I understand that when my Align DUALPartnership coverage begins, I must get all my medical and prescription drug benefits from Align DUALPartnership. Benefits and services provided by Align DUALPartnership and contained in my plan's Align DUALPartnership "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Align DUALPartnership will pay for benefits or that are not covered.
- 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.
- I understand my agent may submit this application electronically on my behalf.

Signature:	**Today's date:**

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

Name:	Address:
Phone number:	Relationship to enrollee: ☐ Agent ☐ Broker ☐ SHIP counselor ☐ Authorized representative ☐ Other (third party) ☐ Self

Section 2 – All fields on this page are optional

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

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer.**

Select one if you want us to send you information in a language other than English.

☐ Spanish ☐ Other

Select one if you want us to send you information in an accessible format. **For documents in alternative format such as braille, audio, or large print please call (888) 605-9277 (TTY: 711).**

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

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

List your Primary Care Physician (PCP): _____

City of PCP: _____

Are you currently this doctor's patient? ☐ Yes ☐ No

Section 2 – All fields on this page are optional

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by receiving a direct bill or **by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have 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. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). Do not pay Sanford Health Plan the Part D-IRMAA.

☐ Deduct from Social Security or Railroad Retirement Board (RRB) benefit. (This can take up to 90 days to set up. Please pay any invoice you receive in the mail.)

☐ Get a bill each month. You may choose from the following payment methods:

Pay by mail: Mail your check, cashier's check or money order made payable to Sanford Health Plan directly to: Sanford Health Plan, PO Box 5076, Sioux Falls SD 57117-5076

Automatic bank draft: After enrollment, visit align.sanfordhealthplan.com/welcome to download the ACH form to have your premium automatically deducted from your bank account each month. Please allow up to 60 days for this to be set up and pay any invoice you receive in the mail.

Section 3 – For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e., agent, broker, SHIP counselor, family member or other (third party)) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee: _____

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

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-NEW. 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 page to send your completed form to the plan.

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.