



Fidelis Care Online Enrollment Authorization Instructions Form

Agent Instructions:

1. Writing Agent must complete and provide a signed copy to the applicant and submit the other to Fidelis Care.
2. Writing Agent must ensure that the applicant reads and understands all disclosures contained in the Fidelis Care Online Enrollment Authorization Form and Application.
3. Please complete the entire form and sign. All fields of the form must be completed. Incomplete forms will not be accepted.
4. Include the Online Confirmation Number generated by the system.
5. Within 24 hours of enrollment, scan and upload the following forms in order to complete enrollment via Fidelis Care Online Medicare Enrollment Portal:
 - Online Enrollment Authorization Form
 - Fidelis Care Branded Scope of Appointment Form
 - Medicare Beneficiary Education Checklist & Comment Sheet



Online Enrollment Authorization Form

You are about to fill out an online application for a Fidelis Care Medicare Advantage Plan. By completing the online application and signing this authorization form, you will be sending an actual enrollment application to Fidelis Care. You will be enrolled in your chosen Medicare Advantage Plan, if the enrollment is approved by the Centers for Medicare and Medicaid Services (CMS). Fidelis Care will notify you via mail of your acceptance or denial following the submission of the enrollment to CMS.

By signing this Online Enrollment Authorization form, I am authorizing my agent to assist me in enrolling in the Fidelis Medicare Plan of my choice using the online enrollment system. My agent has advised me of, and I understand the benefits, cost sharing (i.e., copayments, coinsurance, deductibles) and monthly premium for the plan, if applicable. My agent has provided me with a completed copy of this signed Online Enrollment Authorization Form.

All fields below are mandatory and must be completed by enrollee and agent.

Medicare Advantage Applicant Information

Plan Selection:

Name of Medicare Advantage Plan Selected: _____

Proposed Effective Date: _____

Applicant Information:

Name: _____

Address: _____

Contact #: _____ Gender: Female or Male

Medicare Number _____ Medicaid Number _____

Part A _____ Part B _____ D.O.B _____

Online Confirmation Number: _____

Note: The Online Confirmation number is provided by the system after the online enrollment is completed.

Applicant or Authorized Representative (please attach Power of Attorney)

Signature: _____ Date: _____

Agent Information *(To Be Completed By Agent Assisting With Online Enrollment):*

Agent Name: _____

Agent ID Number: _____ Agent Phone #: _____

Agent Signature: _____ Date _____

**This disclaimer will be read to you before completing
the online enrollment application.**

If you currently have health coverage from an employer or union, joining Fidelis Medicare Advantage/Fidelis Dual Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you enroll in a Fidelis Care Medicare Advantage or Fidelis Dual Advantage plan. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

By completing this enrollment application, I agree to the following:

Fidelis Care Medicare Advantage/Fidelis Dual Advantage Plans are Medicare Advantage plans and have a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in any another Medicare health plan or prescription drug 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 do not 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 when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

Fidelis Care Medicare Advantage/Fidelis Dual Advantage serves a specific service area. If I move out of the area that Fidelis Care Medicare Advantage/Fidelis Dual Advantage 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 Fidelis Care Medicare Advantage/Fidelis Dual

Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Fidelis Care Medicare Advantage/Fidelis Dual Advantage when I get it to know which rules I must follow in order 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.

I understand that beginning on the date Fidelis Care Medicare Advantage/Fidelis Dual Advantage coverage begins; I must get all of my health care from Fidelis Care Medicare Advantage/Fidelis Dual Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Fidelis Care Medicare Advantage and other services contained in my Fidelis Care Medicare Advantage/Fidelis Dual Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR FIDELIS MEDICARE ADVANTAGE WILL PAY FOR THE SERVICES.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contract with Fidelis Care Medicare Advantage/Dual Advantage, he/she may be paid a commission by Fidelis Care for my enrollment in Fidelis Care Medicare Advantage/Dual Advantage.

Release of Information: By joining this Medicare health plan, I acknowledge that the Fidelis Care Medicare Advantage/Dual Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Fidelis Medicare Advantage/Fidelis Dual Advantage 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 Fidelis Medicare Advantage/Fidelis Dual Advantage or by Medicare.