Member Enrollment Package

Relieving financial pressure so you can focus on healing.

When life gets hard, we show up.

Welcome — we're glad this reached you.

The Healing Together Fund connects members facing serious medical conditions with a quality health insurance plan, with no out-of-pocket costs. A licensed agent helps you choose a plan that fits your doctors and prescriptions.

Complete each section that applies to you and sign where indicated. If anything is unclear, call us at 704.847.2321 ext. 305 and we'll walk through it together. Once received, an HTF representative will follow up within one business day.

WHAT'S IN THIS PACKAGE

ABOUT YOU & YOUR HOUSEHOLD

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BEFORE YOU BEGIN — GATHER

- Today's date and your lost-coverage date (if any)
- Social Security numbers & dates of birth for all household members
- Your Medicare card, if you or a family member has Medicare
- Your doctors' contact info and a current medication list

SUBMIT & QUESTIONS

EMAIL destevenson@healingtogetherfund.com

MAIL Healing Together Fund
PO Box 749
Matthews, NC 28106

QUESTIONS 704.847.2321 ext. 305

YOUR PRIVACY IS PROTECTED This application goes directly to the HTF team — your employer is *never* involved and no health information is ever shared with them.

PART A

A Primary Applicant & Spouse / Partner

TODAY'S DATE _____ LOST COVERAGE DATE _____ U.S. CITIZEN? ○ Yes ○ No

PRIMARY APPLICANT

Complete this section for the employee / primary policyholder, even if you are waiving coverage for yourself.

FIRST NAME _____ M.I. _____ LAST NAME _____

DATE OF BIRTH _____ SEX ○ M ○ F SOCIAL SECURITY # _____ MARITAL STATUS ○ Sgl. ○ Mar. ○ Div. ○ Wid.

EMAIL ADDRESS _____ PHONE NUMBER _____

MEDICARE INFORMATION, IF APPLICABLE

ON MEDICARE? ○ No ○ Part A ○ Part B ○ Part A & B

MEDICARE ID # (if any) _____ PART A EFF. DATE _____ PART B EFF. DATE _____

SPOUSE / PARTNER (complete if applicable)

Is your spouse/partner enrolling in coverage? ○ Yes ○ No

FIRST NAME _____ M.I. _____ LAST NAME _____

DATE OF BIRTH _____ SEX ○ M ○ F SOCIAL SECURITY # _____ MARITAL STATUS ○ Sgl. ○ Mar. ○ Div. ○ Wid.

SPOUSE / PARTNER EMAIL _____ SPOUSE / PARTNER PHONE _____

MEDICARE INFORMATION, IF APPLICABLE

ON MEDICARE? ○ No ○ Part A ○ Part B ○ Part A & B

MEDICARE ID # (if any) _____ PART A EFF. DATE _____ PART B EFF. DATE _____

PART B

B Dependents & Address

DEPENDENTS (children and other dependents — leave blank if none)

FULL NAME	DATE OF BIRTH	SOCIAL SECURITY #	SEX M	SEX F	NEEDS COVERAGE? Y	NEEDS COVERAGE? N
			○	○	○	○
			○	○	○	○
			○	○	○	○
			○	○	○	○
			○	○	○	○

PHYSICAL ADDRESS

STREET ADDRESS

_____

CITY _____ COUNTY _____ STATE _____ ZIP CODE _____

MAILING ADDRESS (only if different from physical)

☐ Same as physical address

MAILING STREET ADDRESS

_____

CITY _____ COUNTY _____ STATE _____ ZIP CODE _____

PART C

C Authorization To Disclose Health Information

1. I, _____, hereby authorize the Group Health Plan to release my individually identifiable health information to Healing Together Fund, LLC (HTF) for use in determining whether it may be advantageous for me, my spouse and/or a dependent to voluntarily leave the Group Health Plan and instead purchase an individual policy of health insurance. If HTF determines that it may be advantageous to me, my spouse or a dependent, I further authorize HTF to inform the Employer of that fact and, to the extent necessary or appropriate, to share my individually identifiable health information with the Employer for the purpose of demonstrating the basis for its recommendation. The Employer not the Group Health Plan shall not be permitted to use the information provided by HTF when making any eligibility, enrollment, or employment-related decisions about the undersigned.

2. The type and amount of information to be used or disclosed is as follows:

   A true and complete copy of all medical records, including, but not limited to, all emergency room records, in-patient records, out-patient records, medical reports, narratives, history and physical reports, discharge summaries, x-ray reports, x-ray and imaging study films, diagnostic test results and reports, laboratory test results and reports, medication administration records, billing records and invoices concerning treatment and/or care of said patient, operative reports, pathology reports and records, cytology reports and records, doctors' notes, nurses' notes, consultants' reports, consent forms; any attachments to the jackets containing the medical records of said Patient; a copy of any information related in any way to the Patient which you have transmitted to any company, public or private agency, or person; any other documents in your possession relating to examinations, hospital admissions, and diagnostic testing.

3. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health management department. I understand that revocation will not apply to information that has been released in response to this authorization.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.

I declare under the penalty of perjury that all statements contained in this request and any accompanying documents are true and correct.

SIGNATURE _____ DATE _____

PART D

Marketplace Enrollment Consent

PURPOSE STATEMENT

Registered agents and brokers assisting consumers apply for and enroll in Marketplace coverage must document consumer consent prior to assessing or updating their Marketplace information. CMS does not prescribe the manner in which agents and brokers must document consent. Instead, there are different formats that may be acceptable for agents and brokers to use to document consumer consent, such as via a recorded phone call, text message, email, electronic document with digital signatures, physical document with wet signatures, etc. This model consent form serves as an example for how agents and brokers may document consent via a physical document with wet signatures.

I, _____, give my permission to _____ to serve as the health insurance agent or broker for myself and my entire household if applicable, for purpose of enrollment in a Qualified Health Plan offered on the Federally Facilitated Marketplace. By writing, electronically, or by telephone only for the purposes of one or more of the following: Searching for an existing Marketplace application; Completing an application for eligibility and enrollment in a Marketplace Qualified Health Plan or other government insurance affordability programs, such as Medicaid and CHIP or advance tax credits to help pay for Marketplace premiums; Providing ongoing account maintenance and enrollment assistance, as necessary; or responding to inquiries from the Marketplace regarding my Marketplace application.

I understand that the Agent will not use or share my personally identifiable information (PII) for any purposes other than those listed above. The Agent will ensure that my PII is kept private and safe when collecting, storing, and using my PII for the stated purposes above.

I confirm that the information I provide for entry on my Marketplace eligibility and enrollment application will be true to the best of my knowledge. I understand that I do not have to share additional personal information about myself or my health with my Agent beyond what is required on the application for eligibility and enrollment purposes. I understand that my consent remains in effect until I revoke it, and I may revoke or modify my consent at any time by calling the agent listed below or the agency listed below.

WRITING AGENT

NAME OF PRIMARY WRITING AGENT

_____

AGENT NATIONAL PRODUCER NUMBER

_____

PHONE NUMBER

_____

EMAIL ADDRESS

_____

AGENCY (pre-filled)

AGENCY NAME

Elite Benefits Group

AGENCY NPN

17310201

OWNER

Lucas Hamilton

PHONE

704-289-2320

EMAIL

info@ebgnc.com

PRIMARY HOUSEHOLD CONTACT / AUTHORIZED REPRESENTATIVE & SIGNATURE

NAME OF PRIMARY HOUSEHOLD CONTACT AND/OR AUTHORIZED REPRESENTATIVE

_____

REPRESENTATIVE PHONE NUMBER

_____

EMAIL ADDRESS

_____

SIGNATURE

_____

DATE

_____

PART E — OPTIONAL

E Authorization For Text Messaging

Text messaging is **optional**. If you opt in, **Elite Benefits Group** may send occasional text reminders and updates concerning your health, life, dental, or Medicare insurance. You would be responsible for any message and data rates that apply, and you can reply **STOP** to any message to opt out at any time.

PLEASE CHOOSE ONE

- ◯ **Yes — I authorize Elite Benefits Group to send me text messages.**
- ◯ **No — please do not text me.**

CELL NUMBER	SIGNATURE	DATE

Your choice here never affects your enrollment or your benefits.

F PART F — MEDICARE

Scope Of Appointment Form (Page 1 of 2)

FOR MEDICARE PLANS ONLY

The Centers for Medicare and Medicaid Services requires that Sales Agents document the scope of a personal marketing appointment before meeting with a Medicare beneficiary or their authorized representative. A separate form should be used for each Medicare beneficiary.

Please mark the product(s) you want the agent to discuss.

- ☐ Stand-Alone Medicare Prescription Drug Plans (Part D)
- ☐ Supplemental Health Products
- ☐ Medicare Advantage Plans (Part C) and Cost Plans
- ☐ Medicare Supplement (Medigap) Products
- ☐ Dental/Vision/Hearing Products

By signing this form, you agree to meet with a Sales Agent to discuss the products checked above. The Sales Agent is either employed or contracted by a Medicare plan and may be paid based on your enrollment in a plan. They do not work directly for the federal government. Signing this form does not affect your current or future enrollment in a Medicare plan, enroll you in a Medicare plan or obligate you to enroll in a Medicare plan. All information provided on this form is confidential.

BENEFICIARY OR AUTHORIZED REPRESENTATIVE SIGNATURE AND SIGNATURE DATE

SIGNATURE _____ SIGNATURE DATE _____

If you are the authorized representative, please sign above and print below:

REPRESENTATIVE'S NAME _____ RELATIONSHIP TO BENEFICIARY _____

TO BE COMPLETED BY LICENSED SALES AGENT

AGENT NAME **Erin Koch** AGENT PHONE **704-288-1955**

BENEFICIARY NAME _____ BENEFICIARY PHONE _____

BENEFICIARY ADDRESS _____

INITIAL METHOD OF CONTACT _____ DATE APPT. COMPLETED _____

PLAN(S) THE AGENT REPRESENTED DURING THIS MEETING _____

If the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented 48 hours prior to meeting:

☐ Within last 4 days of valid election period ☐ Walk-in ☐ Other

AGENT SIGNATURE _____

Scope of Appointment — Plan Type Definitions (Page 2 of 2)

REFERENCE — NO SIGNATURE NEEDED

MEDICARE ADVANTAGE PLANS (PART C) AND COST PLANS

Medicare Health Maintenance Organization (HMO):
A Medicare Advantage plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare Preferred Provider Organization (PPO):
A Medicare Advantage plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

Medicare Private Fee-for-Service (PFFS):
A Medicare Advantage plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you—not all providers will. If you join a PFFS plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You'll usually pay more to see out-of-network providers.

Medicare Point of Service (POS):
A type of Medicare Advantage plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. HMO-POS plans may allow you to get some (not all) services out of network for a higher copay or coinsurance.

Medicare Special Needs Plan (SNP):
A Medicare Advantage plan that has a benefit package designed for people with special health care needs. Examples include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

Medicare Medical Savings Account (MSA):
MSA plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

Medicare Cost Plan:
In a Medicare cost plan, you can go to providers both in and out-of-network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you'll be responsible for Medicare coinsurance and deductibles.

STAND-ALONE MEDICARE PRESCRIPTION DRUG (PART D) PLAN

Medicare Prescription Drug Plan (PDP):
A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

OTHER RELATED PRODUCTS

Medicare Supplement (Medigap) Products:
Insurance plans that help pay some of the out-of-pocket costs not paid by Original Medicare Part A and Part B, such as deductibles and coinsurance amounts for Medicare approved services.

Dental/Vision/Hearing Products:
Plans offering additional benefits for consumers who are looking to cover needs for dental, vision, or hearing. These plans are not affiliated or connected to Medicare.

Supplemental Health Products:
Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray copays/coinsurance. These plans aren't affiliated or connected to Medicare.

PART G

Patient Information — Physicians

PRIMARY CARE PHYSICIAN

PHYSICIAN NAME _____ PHONE NUMBER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SPECIALISTS

SPECIALIST _____ PHONE _____

ADDRESS _____ CITY / STATE / ZIP _____

SPECIALIST _____ PHONE _____

ADDRESS _____ CITY / STATE / ZIP _____

SPECIALIST _____ PHONE _____

ADDRESS _____ CITY / STATE / ZIP _____

MEDICAL QUESTIONS

Your answers are confidential and used only to help match you with the right plan and care.

Are you covered by Medicare? ○ yes ○ no

Are you on dialysis? ○ yes ○ no

Are you on chemotherapy? ○ yes ○ no

Are you taking any type of Infusion Therapy? ○ yes ○ no

PART G — CONTINUED

G Medications

NAME _____ DOB _____ TODAY'S DATE _____

PRESCRIPTION MEDICATIONS

NAME (e.g. Propranolol)	DOSAGE (25mg)	FREQUENCY (1/day)	DATE STARTED	REASON / DIAGNOSIS

SUPPLEMENTS / NON-PRESCRIPTION MEDICATIONS

NAME (e.g. Glucosamine)	DOSAGE (500mg)	FREQUENCY (1/day)	DATE STARTED	REASON (Osteoarthritis)

CHECKLIST — BEFORE YOU SUBMIT

- ☐ **A** Primary Applicant & Spouse
- ☐ **B** Dependents & Address
- ☐ **C** Health Information Authorization
- ☐ **D** Marketplace Consent — signed
- ☐ **E** Text Authorization — optional
- ☐ **F** Scope of Appointment
- ☐ **G** Patient Information & Medications

FOR HTF OFFICE USE ONLY

DATE RECEIVED _____

ASSIGNED REPRESENTATIVE _____

STATUS & NOTES _____

SUBMIT YOUR COMPLETED PACKAGE

EMAIL
destevenson@healingtogetherfund.com

MAIL
PO Box 749, Matthews, NC 28106

QUESTIONS
704.847.2321 ext. 305