## Exhibit 29: Model Notice for Enrollment Status Update

Referenced in §50.6

<date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

Your enrollment in <plan> has changed

[Insert one or more of the following, including sufficient detail to describe the specific enrollment change:

You’ll now get your health care services and prescription drug coverage through <plan>

Your <plan> coverage starts <start date> and ends <end date>. [Plan should insert information about how to access coverage, etc.]

**or**

You’ll now get your health care services and prescription drug coverage through <new plan name>

Your enrollment in <name of old plan> has been changed to <name of new plan>. Your coverage with <new plan name> starts <date>. [Plans should insert information on cost sharing information, and other details the individual will need to ensure past and future coverage is clear.]

**or**

Your <plan> health care services and prescription drug coverage will start on <date>

Your coverage in <plan> will start on <date>. This date is earlier than you were originally told. [Plans should include information about coverage, and how to get refunded for prescriptions purchased in the period of retroactive coverage.]

**or**

Your <plan> health care services and prescription drug coverage will start on <date>

Your coverage in <plan> will start on <date>. This date is later than you were originally told. [Plans should insert information about impact to paid claims.]

**or**

Your <plan> health care services and prescription drug coverage [ended or will end] on <date>

Your coverage in <plan> [ended **or** will end] on <date>. This means you [don’t **or** won’t] have coverage through <plan> after this date. [Plans should insert appropriate descriptive information, such as impact on paid claims or how to submit claims, as applicable.]

**or**

Your enrollment in <plan> will end soon

Your <plan> health services will end on <date>. This means you won’t have coverage through <plan> after this date. [Insert information about impact to any paid claims.]

[Insert other pertinent and appropriate information regarding the enrollment status update and the resulting impact to the beneficiary as necessary.]

Who should I call if I have questions about <plan>?

If you have questions, call <plan> Member Services at <toll-free phone number> <days and hours of operation>. TTY users should call <toll-free number>. You can visit <web address>.

You can get this document in Spanish, or speak with someone about this information in other languages for free. Call [insert Member Service phone and TTY/TDD numbers, and hours of operation]. The call is free. *[The previous sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.]*

This information is available for free in other languages and formats like Braille or audio CD.