

Individual Enrollment Request Form to Enroll in a Medicare Advantage Plan (Part C)

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 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 January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit [Medicare.gov](https://www.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 because you don't 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.
- 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:

Emblemhealth Medicare
PO BOX 4001
Farmington CT 06034-9900

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call EmblemHealth at **800-447-9169**.

TTY users can call **711**.

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

En español: Llame a EmblemHealth al 800-447-5496/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.

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.



Please contact EmblemHealth if you need information in another language or format.

Section 1 – To Enroll, Please Provide the Following Information:

Note to Applicant: For information about service area and premiums of EmblemHealth Medicare Advantage plans available to you, please refer to the Summary of Benefits. Please check which plan you want to enroll in:

Four checkboxes for EmblemHealth plans: VIP Dual (HMO D-SNP), VIP Dual Select (HMO D-SNP), VIP Dual Reserve (HMO D-SNP), and VIP Solutions (HMO D-SNP).

LAST Name: FIRST Name: M.I.: Mr. Mrs. Ms.

Birth Date: Sex: M F Home Phone Number: Cell Phone Number:

Email Address: Contact Preference: Mail Email Text Phone

Permanent Residence Street Address (No PO Box):

City: State: ZIP Code:

Mailing Address (only if different from above):

City: State: ZIP Code:

Emergency Contact: Phone Number: Relationship to You:

Medicare Number Part A Part B

Will you have other prescription drug coverage in addition to this plan? Yes No

Name of other coverage: ID # for this coverage: Group # for this coverage:

Are you enrolled in your State Medicaid program? *(Required for enrollment in SNP Plans) Yes No

If "yes," please provide your Medicaid number:

IMPORTANT: Please Read and Sign Below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in EmblemHealth Medicare Advantage Plans.
- By joining this Medicare Advantage Plan, I acknowledge that EmblemHealth Medicare 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 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 disenrolled 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 EmblemHealth Medicare coverage begins, I must get all of my medical and prescription drug benefits from EmblemHealth Medicare. Benefits and services provided by EmblemHealth Medicare and contained in my EmblemHealth Medicare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor EmblemHealth Medicare will pay for benefits or services that are not covered.
- I understand that the phone numbers and/or email I provided on this application may be used by EmblemHealth or any of its contracted parties to contact me about my account, my health benefit plan or related programs, or services provided to me.
- 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.

Your Signature:

Proposed Effective Date:

Today's Date:

If you are the authorized representative, you must sign above and provide the following information:

Name:

Relationship to Enrollee:

Address: _____

Phone Number: (_____) _____ - _____

Section 2

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or visit emblemhealth.com/medicare for additional payment options. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you pay a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay EmblemHealth the Part D-IRMAA.

Would you like the premium for this plan deducted from your SSA or RRB monthly benefit check? Yes No

I get monthly benefits from: Social Security RRB

Please choose the name of a Primary Care Physician (PCP) from our Provider Directory.

Name _____ PCP # _____ Current Patient

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format: Spanish Chinese Large Print

Please contact EmblemHealth at 800-447-9169, TTY: 711, 8 am to 8 pm, seven days a week from October 1 to March 31 and 8 am to 8 pm, Monday to Friday from April 1 to September 30, if you need information in an accessible format or language, other than what is listed above.

Please Complete This Section To Help Determine Which Election Period You Qualify For

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage Plan outside of this period.

Please read the following statements carefully and please 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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| <ul style="list-style-type: none"> <input type="checkbox"/> I am enrolling during the Annual Enrollment Period (AEP) from October 15 to December 7. <input type="checkbox"/> I am new to Medicare. <input type="checkbox"/> I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP). <input type="checkbox"/> 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 ____/____/____. <input type="checkbox"/> I recently was released from incarceration. I was released on ____/____/____. <input type="checkbox"/> I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ____/____/____. <input type="checkbox"/> I recently obtained lawful presence status in the United States. I got this status on ____/____/____. <input type="checkbox"/> I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on ____/____/____. <input type="checkbox"/> I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on ____/____/____. <input type="checkbox"/> 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. <input type="checkbox"/> I am moving into, live in, or recently moved out of a Long Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on ____/____/____. | <ul style="list-style-type: none"> <input type="checkbox"/> I recently left a PACE program on ____/____/____. <input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on ____/____/____. <input type="checkbox"/> I am leaving employer or union coverage on ____/____/____. <input type="checkbox"/> I belong to a pharmacy assistance program provided by my state. <input type="checkbox"/> My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan. <input type="checkbox"/> 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 ____/____/____. <input type="checkbox"/> 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 ____/____/____. <input type="checkbox"/> I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster. <input type="checkbox"/> None of these statements apply to me. |
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If none of these statements apply to you or you're not sure, please contact EmblemHealth at **800-447-9169**, TTY: **711**, 8 am to 8 pm, 7 days a week from October 1 to March 31 and 8 am to 8 pm, Monday to Friday from April 1 to September 30, to see if you are eligible to enroll.

For Company Use Only

Staff Member/Agent/Broker Signature: _____ Agent/Broker ID#: _____

Date Accepted: _____ Source Code: _____ Location: _____

Election Period: ICEP/IEP: _____ AEP: _____ SEP (type): _____

Scope of Appointment (required if not seminar): Yes Seminar No Seminar

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.