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EmblemHealth®

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 Oct. 15–Dec. 7 each year (for coverage starting Jan. 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed 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: 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 (Oct. 15–Dec. 7), the plan must get your completed form by Dec. 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**, 24 hours a day/7 days a week.

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.

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.

EmblemHealth®

2024

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:**

☐ **EmblemHealth VIP Gold (HMO)** ☐ **EmblemHealth VIP Gold Plus (HMO)** ☐ **EmblemHealth VIP Rx Saver (HMO)**

LAST Name:	FIRST Name:	M.I.:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: _____/_____/_____	Sex: ☐ M ☐ F	Home Phone Number: ( )_____-_____	Cell Phone Number: ( )_____-_____
Email Address:			
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: _____

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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 on page 4). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- 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 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 (Date you would like plan to start):	**Today's Date:**

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

Name:_____ **Address:** _____

Phone Number: (_____)_____– _____ **Relationship to Enrollee:** _____

Section 2 – All fields on this page are optional

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

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 (IRMAA), you will be notified by the Social Security Administration (SSA). 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 Provider (PCP) from our Provider Directory.

Name _____ PCP #_____ ☐ Current Patient

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

☐ No, not of Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ **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**

By providing my email above and selecting the box below, I will be enrolled in paperless delivery for some of my plan communications.

☐ I will get many of my required plan communications delivered electronically. We will send you an email when new communications (for example: Explanation of Benefits or the Annual Notice of Changes) are available online. I can access these communications through any device such as a computer, tablet, or mobile phone. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

Please check one of the boxes below if you would prefer us to send you information in a language other than English:

☐ Spanish ☐ Chinese

Please check one of the boxes below if you would prefer us to send you information in an accessible format:

☐ Large Print ☐ Audio ☐ Braille

Please contact EmblemHealth at ***800-447-9169, (TTY: 711), 8 a.m. to 8 p.m., seven days a week from Oct. 1 to March 31 and 8 a.m. to 8 p.m., Monday to Friday from April 1 to Sept. 30 if you need information in an accessible format 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 Oct. 15 through Dec. 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 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.

- ☐ I am enrolling during the Annual Enrollment Period (AEP) from Oct. 15 to Dec. 7.
- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ 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 _____/_____/_____.
- ☐ I recently was released from incarceration. I was released on _____/_____/_____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on _____/_____/_____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on _____/_____/_____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on _____/_____/_____.
- ☐ 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 _____/_____/_____.
- ☐ 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 am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home or skilled nursing facility). I moved/will move into/out of the facility on _____/_____/_____.
- ☐ I recently left a PACE program on _____/_____/_____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on _____/_____/_____.
- ☐ I am leaving employer or union coverage on _____/_____/_____.
- ☐ 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 _____/_____/_____.
- ☐ 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 _____/_____/_____.
- ☐ I was affected by a major disaster or other emergency (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 or other emergency.
- ☐ None of these statements apply to me.

If none of these statements applies to you or you're not sure, please contact EmblemHealth at **800-447-9169** (TTY: **711**), 8 a.m. to 8 p.m., seven days a week from Oct. 1 to March 31 and 8 a.m. to 8 p.m., Monday to Friday from April 1 to Sept. 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 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.