✓MetroPlusHealth | MEDICARE ENROLLMENT REQUEST FORM

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 January1)
- 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: 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), MetroPlusHealth must get your completed form by December 7.
- MetroPlusHealth 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:
MetroPlusHealth
50 Water Street, 7th Floor
NewYork, NY 10004
Attn: Sales & Marketing Dept.

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

How do I get help with this form?

Call MetroPlusHealth at 1-866-986-0356 (TTY users can call 711), Monday to Friday, 8 am – 8pm, and Saturday, 9 am – 5 pm

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

En español: Llame a MetroPlusHealth al 1-866-986-0356 / 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.

SECTION 1 – ALL FIELDS ON THIS PAGE ARE REQUIRED (UNLESS MARKED OPTIONAL)

Select the plan you want to join:

❑ **MetroPlus Platinum Plan** (HMO): **$92.00 per month**

❑ **MetroPlus Advantage Plan** (HMO D-SNP) ‡: **$0 or up to $71.20* per month**

‡ To qualify, you must have Medicaid.

❑ **MetroPlus UltraCare** (HMO D-SNP) †: **$0 or up to $72.30* per month**

† To qualify, you must have Medicaid and demonstrate a need for long-term care services. May we contact you about long-term care services? ❑ Yes ❑ No

* Depending on your level of Low Income Subsidy "Extra Help", your premium cost may be reduced or waived.

FIRST name:	LAST name:	[Optional: Middle Initial]:
Birth date: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Sex: ❑ Male ❑ Female	Phone number: ( )

Permanent Residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):

Street address: City: State: ZIP Code:

YOUR MEDICARE AND MEDICAID INFORMATION:

Medicare Number: _ _ _ _-_ _ _-_ _ _ _ **NY State Medicaid CIN Number** (if any)**:** _ _ _ _ _-_ _ _-_ _ _ _

ANSWER THESE IMPORTANT QUESTIONS:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to MetroPlusHealth?

☐ Yes ☐ No

Name of other coverage: Member number for this coverage: Group number for this coverage:

_____ _____ _____

IMPORTANT: READ AND SIGN BELOW:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in MetroPlusHealth.
- By joining this Medicare Advantage Plan, I acknowledge that MetroPlusHealth 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 PrivacyAct Statement below).
- 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).
- I understand that when my MetroPlusHealth coverage begins, I must get all of my medical and prescription drug benefits from MetroPlusHealth. Benefits and services provided by MetroPlusHealth and contained in my MetroPlusHealth "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor MetroPlusHealth will pay for benefits or services that are not covered.
- 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.

(continues on the next page)

SECTION 1 Continued – ALL FIELDS ON THIS PAGE ARE REQUIRED (UNLESS MARKED OPTIONAL)

• 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.

Signature:	**Today's date:**
If you're the authorized representative, sign above and fill out these fields:	
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.

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

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

What is your gender? Select one.

- ❑ Woman
- ❑ Man
- ❑ Non-binary
- ❑ I use a different term: _____
- ❑ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

- ❑ Lesbian or gay
- ❑ Straight, that is, not gay or lesbian
- ❑ Bisexual
- ❑ I use a different term: _____
- ❑ I don't know
- ❑ **I choose not to answer**

Select one if you want us to send you your significant documents in a language other than English.

❑ Spanish ❑ Chinese

Select one if you want us to send you your significant documents in an accessible format.

❑ Braille ❑ Large print ❑ Audio CD ❑ Data CD

Please contact MetroPlusHealth at 1-866-986-0356 (TTY users should call 711) if you need information in an accessible format or language other than what is listed above. Our office hours are: Monday to Friday, 8 am – 8pm, and Saturday, 9 am – 5 pm.

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.

SECTION 2 Continued –ALL FIELDS ON THIS SECTION ARE OPTIONAL

Do you work? ❑ Yes ❑ No Does your spouse work? ❑ Yes ❑ No

List your Primary Care Physician (PCP), clinic, or health center:	Provider's ID #:	PORG ID #:

❑ I want to get significant plan materials via email by calling MetroPlusHealth at 1-866-986-0356 (TTY users should call 711) and requesting the material be emailed to me. By checking this box, I consent to receive these materials by email upon my request. I understand I can opt-out at any time.

E-mail address:

PRE-ENROLLMENT CHECKLIST (PECL) ATTESTATION

❑ I have received the Pre-Enrollment Checklist (PECL) and fully understand MetroPlusHealth's Plan benefits and rules.

SECTION 3 – ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

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. Qualifications below are subject to Plan determination.

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 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 (insert date) _____.

❑ I recently was released from incarceration. I was released on (insert date) _____.

❑ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.

❑ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.

❑ I recently had a change in my Medicaid or Low-Income Subsidy (LIS / "Extra Help") status (newly eligible, had a change in level of assistance, or lost eligibility) on (insert date) _____.

❑ I have Medicaid with MetroPlusHealth and want to combine my coverage by joining a MetroPlusHealth Medicare plan.

❑ 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 / moved out of the facility on (insert date) _____.

❑ I recently left a PACE program on (insert date) _____.

❑ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.

❑ I am leaving employer or union coverage on (insert date) _____.

❑ 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.

SECTION 3 Continued – ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

- ❑ 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 (insert date) _____.
- ❑ 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 (insert date) _____.
- ❑ I was affected by an emergency or major disaster (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.
- ❑ Other: _____

If none of these statements applies to you or you're not sure, please contact MetroPlusHealth at 1-866-986-0356 (TTY users should call 711) to see if you are eligible to enroll. We are open Monday to Friday, 8 am – 8pm, and Saturday, 9 am – 5 pm.

PAYING YOUR PLAN PREMIUMS

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or credit card each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month. Please select a premium payment option (**If you don't select a payment option, you will get a bill each month):

- ❑ Get a bill
- ❑ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from: ❑ Social Security ❑ RRB

(The Social Security / RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction). In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.) **If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium.** The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay MetroPlusHealth the Part D-IRMAA.

FOR INDIVIDUALS HELPING ENROLLEE WITH COMPLETING THIS FORM ONLY

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name:	Relationship to enrollee:
Signature:	**Today's date:**

OFFICE USE ONLY

Name of Staff Member / Agent / Broker (if assisted in enrollment):

_____ Date Received: _____

National Producer Number (Agents/Brokers only): _____

Plan ID #:_____ Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ OEP: _____ SEP (type): _____ Not Eligible: _____

Marketing: Rep Code: _____ Site ID Code: _____

Event Name: _____