✓MetroPlusHealth | SHORT ENROLLMENT REQUEST FORM

PLEASE NOTE: You should only use this form if you are changing from one MetroPlus Medicare Advantage plan to another. Do not use this form if you are enrolling in a MetroPlus Medicare Advantage plan for the first time or if you are a previous member of a MetroPlus Medicare Advantage plan but have disenrolled from the plan.

Please fill out the following:

I am currently a member of the _____ plan in MetroPlusHealth.

I would like to change to the following plan in MetroPlusHealth:

- ❑ **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

I understand that this plan has different health benefits.

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

Name:	Home Phone Number:
Medicare Number:	**NY State Medicaid CIN Number (if applicable):**

Permanent 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 (only if different from your Permanent Street Address):
Street Address: City: State: ZIP Code:

Name of chosen Primary Care Physician (PCP), clinic or health center:	**Provider's ID #:**

SECTION 2 – ALL FIELDS IN THIS SECTION 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.**

SECTION 2 – ALL FIELDS IN THIS SECTION ARE OPTIONAL (CONTINUED)

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**

Please check one of the boxes below if you would prefer us to send your significant documents in a language other than English or in an accessible format 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. We are open Monday to Friday, 8 am – 8pm, and Saturday, 9 am – 5 pm. Please contact us if you need information in an accessible format or language other than what is listed:

❑ Spanish ❑ Chinese ❑ Braille ❑ Large print ❑ Audio CD

Email address: _____

YOUR PLAN PREMIUM

If you are enrolling with a $0 premium: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail, credit card, check, or money order upon receipt of notice from MetroPlusHealth. You can also pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed 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 the RRB. Do NOT pay MetroPlusHealth the Part D-IRMAA.

If you are enrolling with any premium amount other than $0: You can pay your monthly plan premium including any late enrollment penalty you have or may owe) by mail by mail, credit card, check, or money order each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month. If you are assessed 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 the Railroad Retirement Board. Do NOT pay MetroPlusHealth the Part D-IRMAA.

YOUR PLAN PREMIUM (CONTINUED)

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.
Please select a premium payment option:

❑ 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 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.)

PLEASE READ AND SIGN BELOW (CONTINUED ON NEXT PAGE):

MetroPlusHealth is a plan that has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with MetroPlusHealth, he/she may be paid based on my enrollment in MetroPlusHealth.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that MetroPlusHealth will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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 aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date MetroPlusHealth coverage begins, I must get all of my health care from MetroPlusHealth, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by MetroPlusHealth and other services contained in my MetroPlusHealth Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **WITHOUT AUTHORIZATION, NEITHER MEDICARE NOR METROPLUSHEALTH WILL PAY FOR THE SERVICES.**

PLEASE READ AND SIGN BELOW (CONTINUED)

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (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 from Medicare.

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

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 0938-1378. 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.

Signature:	**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: _____

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: _____