

ALL FIELDS ON THIS FORM ARE OPTIONAL*. Answering these questions is your choice. You can't be denied coverage because you don't fill them out. *Responses collected below are for internal plan purposes only and will not be shared with CMS.

Name: _____

Phone number: _____

Address: _____

Relationship to enrollee: _____

- Selected plan:
- MetroPlus Advantage Plan** (HMO D-SNP)
 - MetroPlus UltraCare** (HMO D-SNP)
 - MetroPlus Platinum Plan** (HMO)

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.**

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**

BENEFICIARY OR AUTHORIZED REPRESENTATIVE SIGNATURE AND SIGNATURE DATE:

Applicant's Printed Name

Applicant's Signature

Date

If you are the authorized representative, please complete, sign and print clearly below:

Your Relationship to the Beneficiary: _____

Applicant's Printed Name

Applicant's Signature

Date