

Name: _____

Phone number: _____

Address: _____

Relationship to enrollee: _____

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

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 or nursing home. 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’m in a qualified State Pharmaceutical Assistance Program, or I’m losing help from a State Pharmaceutical Assistance Program..

