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elderplan®
a participating agency of MJHS Health System

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN (MAPD)

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.

Reminder:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.

Reminder:

- 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:

ELDERPLAN
ATTN MEMBER OPERATIONS
55 WATER STREET, 46TH FLOOR
NEW YORK, NY 10041

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

How do I get help with this form?

Call Elderplan Member Services at 1-800-353-3765. TTY users can call 711. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Elderplan al 1-800-353-3765 / TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 8 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:

- ❑ **Elderplan** for Medicaid Beneficiaries (HMO-POS D-SNP) – $31.30 per month
- ❑ **Elderplan** Advantage for Nursing Home Residents (HMO-POS I-SNP) – $34.30 per month
- ❑ **Elderplan** Plus Long-Term Care (HMO-POS D-SNP) – $0.00 per month
- ❑ **Elderplan** Extra Help (HMO-POS) – $41.00 per month
- ❑ **Elderplan** Flex (HMO-POS) – $0.00 per month

  Choose one of the following **Select Extra** benefits:

  - ❑ Over-the-Counter (OTC)
    OR
  - ❑ Transportation

- ❑ **Elderplan** Select (HMO-POS I-SNP/IE-SNP) – $0.00 per month

FIRST name: LAST name: Optional: Middle Initial:

Birth date: (MM/DD/YYYY) (___/___/_____)

Sex:

- ❑ Male
- ❑ Female

Home phone number: ( )
Cell phone number: ( )

Opt-in to receive the following SMS text notifications:

- Health plan information: ❑ Yes ❑ No
- Wellness information: ❑ Yes ❑ No
- Incentives and Surveys: ❑ Yes ❑ No

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: | Optional: County: | State: | ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):
Street address: City: State: ZIP Code:

Do you have an email? If Yes: _____

Your Medicare information:

Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Elderplan? ❑ Yes ❑ No

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

To enroll in a Elderplan Dual-Special Needs Plan you must meet the criteria listed below and live in our plan service areas:

Are you enrolled in your New York State Medicaid Program? ❑ Yes ❑ No

If yes, please provide your New York State Medicaid number: _____

- **Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP), you must be entitled to Medicare and New York State Medicaid Program, you must be eligible for Medicaid coverage and meet the enrollment eligibility requirements for Elderplan for Medicaid Beneficiaries. The kind of Medicaid benefits you receive are determined by New York State and may vary based upon your income and resources.**

  Are you eligible for Medicare cost-sharing assistance under New York State Medicaid? ❑ Yes ❑ No

- **Elderplan Plus Long-Term Care (HMO-POS D-SNP) you must be entitled to Medicare and New York State Medicaid Program, you must be eligible for full benefits from Medicaid and meet the enrollment eligibility requirements for Elderplan Plus Long-Term Care. The kind of Medicaid benefits you receive are determined by New York State and may vary based upon your income and resources.**

  Please indicate if you meet all the following requirements. 1) You are eligible for full New York State Medicaid coverage, 2) you are 18 years or older, and 3) you believe you are eligible for a nursing home level of care, are capable of safely remaining in your home, and require care management and home care or day care services for 120 continuous days or longer?

  ❑ Yes ❑ No

Answer these important questions:

To enroll in a Elderplan Special Needs Plan you must meet the criteria listed below and live in our plan service areas:

- **Elderplan Advantage for Nursing Home Residents (HMO-POS I-SNP) you must live in an institutional nursing home contracted with Elderplan Special Needs Plan.**

  Do you reside or expect to reside in a contracted nursing facility within the service area? ❑ Yes ❑ No

  If "yes," please provide the following information:

  Name of Institution: _____

  Address & Phone Number of Institution (number and street): _____

- **Elderplan Select (HMO-POS I-SNP/IE-SNP) your current address should be in an Elderplan contracted congregate care setting while also receiving nursing home level of care OR you live in a skilled nursing facility contracted with Elderplan Special Needs Plan.**

  Do you reside or expect to reside in a Congregate Care Facility within the service area while also getting nursing home level of care? ❑ Yes ❑ No

  – or –

  Do you reside or expect to reside in a contracted nursing facility within the service area? ❑ Yes ❑ No

  If "yes," please provide the following information:

  Name of Institution: _____

  Address & Phone Number of Institution (number and street): _____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Elderplan.
- By joining this Medicare Advantage Prescription Drug Plan, I acknowledge that Elderplan 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 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 Elderplan coverage begins, I must get all of my medical and prescription drug benefits from Elderplan. Benefits and services provided by Elderplan and contained in my Elderplan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Elderplan 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.
- 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:
Agent Name:	**Enrollment Effective date:**
National Producer Number (Agents/Brokers only): _____	

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
- ❑ Black or African American
- ❑ White
- ❑ **I choose not to answer.**

Asian:

- ❑ Asian Indian
- ❑ Chinese
- ❑ Filipino
- ❑ Japanese
- ❑ Korean
- ❑ Vietnamese
- ❑ Other Asian

Native Hawaiian and Pacific Islander:

- ❑ Guamanian or Chamorro
- ❑ Native Hawaiian
- ❑ Samoan
- ❑ Other Pacific Islander

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 information in a language other than English.

❑ Spanish ❑ Chinese ❑ Other _____

What is your preferred spoken language other than English? Select one:

❑ Spanish ❑ Chinese ❑ Other _____

Select one if you want us to send you information in an accessible format.

❑ Braille ❑ Large print ❑ Audio CD ❑ Data CD

Please contact Elderplan at 1-800-353-3765 if you need information in an accessible format other than what's listed above. Our office hours are 8 AM to 8 PM, 7 days a week. TTY users can call 711.

Do you work? ❑ Yes ❑ No

Does your spouse work? ❑ Yes ❑ No

List your Primary Care Physician (PCP), clinic, or health center:

I want to get the following materials via email. Select one or more.

- ❑ Evidence of Coverage
- ❑ Summary of Benefits
- ❑ Annual Notice of Change
- ❑ Formularies

E-mail address: _____

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, "Electronic Funds Transfer (EFT)", 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.**

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. DON'T pay Elderplan the Part D-IRMAA.

Please select a premium payment option:

- ❑ Get a bill.
- ❑ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:
  Account holder name: _____
  Bank routing number: _ _ _ _ _ _ _ _ _
  Bank account number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
  Account type: ❑ Checking ❑ Saving
- ❑ Credit Card. Please provide the following information:
  Type of Card: _____
  Name of Account holder as it appears on card: _____
  Account number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
  Expiration Date: _ _ /_ _ _ _ (MM/YYYY)
- ❑ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

  I get monthly benefits from: ❑ Social Security ❑ Railroad Retirement Board (RRB)

  (The Social Security or 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.)

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.

Enrollee Representative Name: _____ Relationship to Enrollee: _____

Enrollee Representative Signature: _____

National Producer Number (Agents/Brokers only): _____

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.