

Capital Health Plan Retiree Advantage (HMO)						
2026 Enrollment Application						
Secti	on 4: Enrollment Informatio	on				
Empl	oyer Information					
	oyer Name (Retirement Ber p#:	nefits):				
□ Ret □ I ha	of Florida Members Only: ciree Advantage ☐ Retire eve contacted People First (19 of my Medicare card.	ee Classic	735) to	report	plan selection and will sen	d a
Perso	onal Information					
•	Last Name:					
•	FirstName:					
•	MiddleInitial:					
•	☐ Mr. ☐ Mrs. ☐ Ms.					
•	Date of Birth (mm/dd/yyyy	/):				
•	Sex: ☐ Male ☐ Female					
•	Home Phone:					
Perm	anent Residence (No P.O.	Box)				
•	Street Address:					
•	City:	State:		ZIP: _		
Mailir	ng Address (If Different)  Street Address:					

• City: \_\_\_\_\_ State: \_\_\_\_ ZIP: \_\_\_\_



Emergency Contact (Optional)
• Name:
• Phone (Home):
Phone (Cell):
- Thore (cen)
Medicare Information
Medicare Number (from Red, White, and Blue card):
☐ I have both Medicare Part A and B
Section 5: Eligibility Questions
1. <b>Are you the policyholder?</b> □ Yes □ No
- Retirement Date:
- Last Active Coverage Date:
If Yes:
- Covering spouse or dependents? $\square$ Yes $\square$ No
- Spouse Name:
- Dependents:
If No:
- Policyholder Name:
- Retirement Date:
- Last Active Coverage Date:
Demographic Information (Optional)
2. Are you of Hispanic, Latino/a, or Spanish origin?
☐ No ☐ Yes - Select all that apply:
☐ Mexican/Mexican American/Chicano/a ☐ Puerto Rican ☐ Cuban
☐ Another Hispanic/Latino origin ☐ I choose not to answer





3.	What is your race? (Select all that apply)					
	☐ American Indian/Alaska Native ☐ Asian Indian ☐ Black/African American					
	☐ Chinese ☐ Filipino ☐ Guamanian/Chamorro ☐ Japanese ☐ Korean					
	☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan					
$\square$ Vietnamese $\square$ White $\square$ I choose not to answer						
4.	Preferred Language (if not English):					
	☐ Spanish ☐ Other:					
Section	on 6: Additional Coverage and Provider Information					
	•					
Do yo	u or your spouse work? □ Yes □ No					
5.	Will you have other prescription drug coverage? ☐ Yes ☐ No					
	If Yes:					
	- CoverageName:					
	- Member ID #:					
	- Group #:					
6.	Primary Care Physician (PCP):					
	Are you an established patient? $\square$ Yes $\square$ No					
7.	Would you like to receive materials by email?					
	☐ Evidence of Coverage ☐ Annual Notice of Change					
	Email:					
8.	Would you like information in an accessible format? ☐ Yes ☐ No					
	If Yes, select one:					
	☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD					

Section 7: Enrollment Agreement

By completing this application, I agree to the following:

- I will keep both Medicare Part A and B to remain enrolled.
- I authorize Capital Health Plan to share my information with Medicare for processing.
- I confirm that the information I provided is accurate.

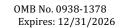


• I understand I must use Capital Health Plan providers.

Method of Contact:

- I understand Medicare won't pay for out-of-network services unless specified.
- I agree my signature or that of my authorized representative validates this application.

Privacy Act Statement
Capital Health Plan may share your information with CMS as allowed by federal law. You are not required to respond, but failure to do so may affect enrollment.
Enrollment Confirmation
Confirmation Number: Date of Application:
Authorized Representative (If Applicable)
• Name:
• Phone:
• Address:
RelationshiptoEnrollee:
Office Use Only
Agent/Broker Name:
Agent/Broker Number:
Application Date:
EffectiveCoverageDate:
• Eligibility Code:  □ ICEP/IEP □ AEP □ SEP(Type): □ STAR(R) □ Not Eligible





## Section 8: Special Enrollment Period (SEP) Checkboxes

Please check all that apply if applying outside of the October 15 - December 7 annual						
enrollment period:						
☐ I am new to Medicare						
☐ I am making a change during MA OEP						
☐ I recentlymoved (Date:)						
☐ I was recently released from incarceration (Date:)						
☐ I returned to the U.S. (Date:)						
☐ I recently gained lawful presence (Date:)						
☐ Change in Medicaid (Date:)						
☐ Change in Extra Help (Date:)						
$\square$ I have both Medicare and Medicaid						
$\square$ I live or moved into/out of a long-term care facility (Date:)						
☐ I left a PACE program (Date:)						
☐ I involuntarily lost drug coverage (Date:)						
☐ I left employer/union coverage (Date:)						
$\square$ I belong to a state pharmacy assistance program						
$\square$ My plan is ending contract with Medicare						
☐ I lost SNP eligibility (Date:)						
$\square$ I was affected by FEMA-declared emergency						
☐ My current plan is in receivership						
☐ I am in a plan marked with low-performing icon (LPI)						
Final Steps						
MSR Statement:						
This completes the application. Do you have any questions?						
☐ Yes ☐ No (Answer questions if yes)						
You will receive confirmation of your enrollment within 10 days, followed by your plan						
documents and ID cards.						
Signature/Confirmation Number Format:						
Plan ID (e.g., H5938 802 or H5938 804) + Application #(e.g., 00001) + Date (MMDDYYYY)						