OMB No. 0938-1378
Expires 7/31/2024

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

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 January 1)
- 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.

Reminders:

- 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.
- 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?

Mail your completed and signed form to:
Capital Health Plan, P.O. Box 15349, Tallahassee, Florida 32317-5349
Fax to Capital Health Plan Enrollment Department at 850-523-7369 or email at enrollment@chp.org

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

How do I get help with this form?

Call Capital Health Plan at 850-523-7441 or 1-877-247- 6512 (TTY 850-383-3534 or 1-877- 870-8943) 8:00 a.m. – 8:00 p.m., seven days a week, October 1 – March 31; 8:00 a.m. – 8:00 p.m., Monday Friday, April 1 – September 30.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY 1-877-486-2048.

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.

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Capital Health PLAN℠
An Independent Licensee of the Blue Cross and Blue Shield Association

To Enroll in Capital Health Plan in 2024, Please Provide the Following Information:

Section 1 – All Fields on this page are required (unless marked optional)

Please check which plan you want to enroll in:

☐Silver Advantage (HMO) $0/mo.	☐Advantage Plus (HMO) $26/mo.	☐Preferred Advantage (HMO) $86/mo.

Member Name (Last, First MI):

Birth Date:	**Sex:** ☐ M ☐ F	**Home Phone:**	**Cell:**

Permanent Residence (PO Box is not allowed)

Street Address:	City, ST Zip:	County:

Mailing Address, if different from your permanent residence address (PO Box is allowed)

Street Address:	City, ST Zip:	County:
Emergency contact:	Home Phone:	Cell:

Please Provide Your Medicare Insurance Information:

Medicare Number: ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Answer This Important Question:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Capital Health Plan? ☐Yes ☐No
Name of other coverage:_____ _____
Member ID # for this coverage:_____ Group # for this coverage: _____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Capital Health Plan.
- By joining this Medicare Advantage Plan, I acknowledge that Capital Health Plan 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.
- 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 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
- I understand that when my Capital Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Capital Health Plan. Benefits and services provided by Capital Health Plan and contained in my Capital Health Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Capital Health Plan will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person 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 from Medicare.

Signature:	**Today's Date:**
If you're the authorized representative, sign above and fill out these fields:	
Name:	**Phone:**
Address:	**Relationship to Enrollee:**

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
☐ **I choose not to answer**.
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Cuban

What is your race? Select all that apply:

☐ American Indian or Alaska Native
☐ Chinese
☐ Japanese
☐ Other Asian
☐ Vietnamese
☐ **I choose not to answer.**
☐Asian Indian
☐ Filipino
☐ Korean
☐ Other Pacific Islander
☐ White
☐ Black or African American
☐ Guamanian or Chamorro
☐ Native Hawaiian
☐ Samoan

Select one if you want us to send you information in an accessible format: ☐ Braille ☐ Large Print ☐ Audio CD

Please contact our Member Services Department at 850-523-7441 or 1-877-247-6512 if you need information in an accessible format other than what's listed above. Our office hours are 8:00 a.m. – 8:00 p.m., seven days a week, October 1 – March 31; 8:00 a.m. – 8:00 p.m. Monday – Friday, April 1 – September 30. TTY users can call 850-383-3534 or 1-877-870-8943.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

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

Are you an established patient of this primary care physician? ☐ Yes ☐ No

I want to get the following materials via email. Select one or more: ☐ Evidence of Coverage ☐ Annual Notice of Change
Email address: _____

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or by "Electronic Funds Transfer (EFT) each month. **You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check 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 Capital Health Plan 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. If you mark this option but do not include a voided check, you will get a paper bill each month.**
☐ Automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefits check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. **If your automatic deduction does not begin on your enrollment effective date, you will be asked to pay your first month's premium directly to Capital Health Plan.** If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

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PRIVACY ACT STATEMENT

The Center 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. Section 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.

Office Use Only:

Name of Agent/Broker (if assisted in enrollment):_____ Agent/Broker/NP# _____

Date _____ Effective Date of Coverage: _____

ICEP/IEP:____ AEP:_____ SEP (type):_____ STAR (R)_____ Not Eligible:_____

Please Read This Important Information:

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15th through December 7th of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period. If you are applying outside of the annual enrollment period, 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 (newly enrolled in Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date)_____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly enrolled in Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/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 belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date)_____.

- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.
- ☐ I am currently enrolled in a plan that is experiencing financial difficulties to such an extent that a state or territorial regulatory authority has placed the organization in receivership.
- ☐ I am currently enrolled in a plan identified with the low performing icon (LPI)

If none of these statements apply to you or you're not sure, please contact Capital Health Plan to see if you are eligible to enroll. We can be reached at 850-523-7441 or 1-877-247-6512 (TTY 850-383-3534 or 1-877- 870-8943) 8:00 a.m. – 8:00 p.m., seven days a week, October 1 – March 31; 8:00 a.m. – 8:00 p.m., Monday–Friday, April 1 – September 30.