

**To Enroll in Capital Health Plan Retiree Advantage (HMO) in 2025,  
Please Provide the Following Information:**



<b>Name of Employer your Retirement Benefits are with:</b>	<b>Group #:</b>
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**State of Florida Members Only:** Please choose your plan:  Retiree Advantage  Retiree Classic  
*State of Florida Retirees please contact Peoples First for notification of plan selection and send copy of Medicare card. Toll-free 1-866-663-4735 Monday through Friday, 8:00 a.m. to 6:00 p.m. EST.*

<b>Member Name</b> (Last, First MI: _____)			
<b>Birth Date:</b> / /	<b>Sex:</b> <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ( )	
<b>Permanent Residence</b> (PO Box is not allowed):		Street: _____	
City: _____	State: _____	ZIP Code: _____	County: _____
<b>Mailing Address</b> (If different from your permanent residence):		Street: _____	
City: _____	State: _____	ZIP Code: _____	County: _____
<b>Emergency Contact Information</b>		Name: _____	Home: _____
		Cell: _____	

**Please Provide Your Medicare Insurance Information**

**Medicare Number:** \_\_\_\_\_

**Please Read And Answer These Important Questions**

1. Are you the policyholder?  Yes  No  
**If Yes**, retirement date? (mm/dd/yyyy): \_\_\_\_\_ Last date covered as active employee: \_\_\_\_\_

If you **are** the policyholder, are you covering a spouse or dependents under this employer plan?  
 Yes  No Name of spouse, if applicable: \_\_\_\_\_  
 Name of dependents, if applicable: \_\_\_\_\_

If you are **not** the policyholder, what is the policyholder's name? \_\_\_\_\_  
 Policyholder's retirement date (mm/dd/yyyy): \_\_\_\_\_ Last date covered as active employee: \_\_\_\_\_

2. Will you have other prescription drug coverage (like VA, TRICARE) in addition to CHP?  Yes  No  
 If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:  
 Name of other coverage: \_\_\_\_\_ Member ID # for this Coverage: \_\_\_\_\_ Group # for this Coverage: \_\_\_\_\_

**IMPORTANT: Read and Sign Below:**

**By completing this enrollment application, I agree to the following:**

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Capital Health Plan. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another individual Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15<sup>th</sup> – December 7<sup>th</sup> of every year), or under certain special circumstances.
- Capital Health Plan serves a specific service area. If I move out of the area that Capital Health Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Capital Health Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Capital Health Plan when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug 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 when my Capital Health Plan Retiree Advantage (HMO) 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 are the Authorized Representative, sign above and fill out these fields**

**Name:**

**Address:**

**Phone Number:**

**Relationship to Enrollee:**

**Office Use Only:**

Name of Agent/Broker: \_\_\_\_\_ Agent/Broker Number: \_\_\_\_\_

Date Application Accepted \_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_

ICEP/IEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP (type) \_\_\_\_\_ STAR (R): \_\_\_\_\_ Not Eligible \_\_\_\_\_

**Answering these questions is your choice. You can't be denied coverage because you don't fill them out**

3. List your Primary Care Physician (PCP, clinic, or health care): \_\_\_\_\_

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

4. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply:

- |   |  |
|---|--|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin   | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican                                  | <input type="checkbox"/> Yes, Cuban                                |
| <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> <b>I choose not to answer.</b>            |

5. What is your race? Select all that apply:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Asian Indian           | <input type="checkbox"/> Black or African American      |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Filipino               | <input type="checkbox"/> Guamanian or Chamorro          |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Korean                 | <input type="checkbox"/> Native Hawaiian                |
| <input type="checkbox"/> Other Asian                      | <input type="checkbox"/> Other Pacific Islander | <input type="checkbox"/> Samoan                         |
| <input type="checkbox"/> Vietnamese                       | <input type="checkbox"/> White                  | <input type="checkbox"/> <b>I choose not to answer.</b> |

6. What is your gender? Select one.

- |                                     |  |
|-------------------------------------|--|
| <input type="checkbox"/> Woman      | <input type="checkbox"/> I use a different term: |
| <input type="checkbox"/> Man        | <input type="checkbox"/> I choose not to answer  |
| <input type="checkbox"/> Non-binary |  |

7. Which of the following best represents how you think of yourself? Select one.

- |  |  |
|--|--|
| <input type="checkbox"/> Lesbian or gay                        | <input type="checkbox"/> I use a different term: |
| <input type="checkbox"/> Straight, that is, not gay or lesbian | <input type="checkbox"/> I don't know            |
| <input type="checkbox"/> Bisexual                              | <input type="checkbox"/> I choose not to answer  |

8. Select one if you want us to send you information in a language other than English.

9.  Spanish  Other \_\_\_\_\_

6. Do you work?  Yes  No Does your spouse work  Yes  No

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

- Evidence of Coverage  Annual Notice of Change

Email address: \_\_\_\_\_

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

- Braille     Large Print     Audio CD     Data 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. State of Florida members call 1-877-392-1532, 7:00 a.m. – 7:00 p.m. TTY users can call 850-383-3534 or 1-877-870-8943.

**Please Read And Answer These Important Questions:**

**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 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 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.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date).
- 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/my spouse have retired and my active coverage under my employer will end 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 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)