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

Enrollment Request Form to Enroll in a Medicare Advantage Plan (Part C) with Medicare Prescription Drug Plan (Part D)

Who can use this form?

People with Medicare and Medicaid 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 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?

Send your completed and signed form to:

Nascentia Health Plus
1050 West Genesee Street
Syracuse, NY 13204

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

How do I get help with this form?

Call Nascentia Health Plus at 888-477-4663 (TTY 711)

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

En español: Llame a Nascentia Health Plus al 888-477-4663-/TTY 711 o a Medicare gratis al 800-633-4227 y oprima el 2 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:

- ☐ Nascentia Dual Advantage (003): $0 per month
- ☐ Nascentia Skilled Nursing Facility (002): $0 per month
- ☐ Nascentia Medicaid Advantage Plus (001): $0 per month

FIRST name: LAST name: Middle Initial (*Optional*):

Birth date (MM/DD/YYYY): __ __/__ __/__ __ __ __ Sex: ☐ Male ☐ Female

Phone: (__ __ __) __ __ __-__ __ __ __ Email:

Permanent Residence Street Address (*do not enter a PO Box*): _____

City: County (*Optional*): State: ZIP:

Mailing address, if different from permanent address (*PO Box allowed*):

Street Address: City: State: ZIP:

Your Medicare information

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

Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Nascentia Health Plus? ☐ Yes ☐ No

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

Are you enrolled in your state Medicaid Program? ☐ Yes ☐ No

If yes, please provide your Medicaid number: _____

IMPORTANT: Read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Nascentia Health Plus.
- By joining this Medicare Advantage Plan, I acknowledge that Nascentia Health Plus 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Nascentia Health Plus coverage begins, I must get all my medical and prescription drug benefits from Nascentia Health Plus. Benefits and services provided by Nascentia Health Plus and contained in my Nascentia Health Plus "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Nascentia Health Plus will pay for benefits or services that are not covered.
- 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:

Section 2—All fields on this page are optional

Answering these questions is your choice. You cannot 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's 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 Nascentia Health Plus at 1-888-477-4663 if you need information in an accessible format other than what's listed above. Our office hours are 7 days a week, 8am–8pm October 1–March 31. Monday–Friday, 8am–8pm the rest of the year. TTY users call 711.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No ☐ Not Applicable

List your primary care physician (PCP), clinic, or health center:

Enrollee email 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 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. DO NOT pay Nascentia Health Plus the Part D-IRMAA.

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.

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 ⇨ __ __/__ __/__ __ __ __
- ☐ I recently was released from incarceration. I was released on ⇨ __ __/__ __/__ __ __ __
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ⇨ __ __/__ __/__ __ __ __
- ☐ I recently obtained lawful presence status in the United States. I got this status on ⇨ __ __/__ __/__ __ __ __
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on ⇨ __ __/__ __/__ __ __ __
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on ⇨ __ __/__ __/__ __ __ __
- ☐ 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 ⇨ __ __/__ __/__ __ __ __
- ☐ I recently left a PACE program on ⇨ __ __/__ __/__ __ __ __
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on ⇨ __ __/__ __/__ __ __ __
- ☐ I am leaving employer or union coverage on ⇨ __ __/__ __/__ __ __ __
- ☐ 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 plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on ⇨ __ __/__ __/__ __ __ __
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on ⇨ __ __/__ __/__ __ __ __
- ☐ 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 ⇨ __ __/__ __/__ __ __ __
- ☐ 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 a natural disaster.
- ☐ **None of these statements apply to me or I'm not sure.** Please contact Nascentia Health Plus to see if you are eligible to enroll at 888-477-4663/TTY 711, 8am–8pm seven days a week, Oct. 1–Mar. 31. From April 1–Sept. 30, M–F, our hours are 8am–8pm.

Enrollee or authorized representative, sign and fill out information below			
Signature		Date	
Name		Phone	
Address		Relationship to Enrollee	
Office Use Only			
Agent		Signature	
Plan ID #	Effective Date:	Date Received:	
ICEP/IEP ☐	AEP ☐	SEP (type) ☐	Not Eligible ☐