El Paso Health Advantage Dual SNP (HMO D-SNP)

Individual Enrollment Request Form - 2021

Be sure to complete the entire Enrollment Form. Please contact El Paso Health Advantage Dual SNP at 1-833-742-3125 (TTY 711) if you need information in another language or format (Large Print or Braille).

To enroll in El Paso Health Advantage Dual SNP, please provide the following Information:

Please check which plan you want to enroll in: ☐ El Paso Health Advantage Dual SNP (HMO D-SNP) **$0.00 per month**

FIRST Name:	LAST Name:	(Optional) Middle Initial:

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

Permanent Residence Street Address (Don't enter a PO Box):

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

Mailing Address, if different from your Permanent Residence Address(PO Box allowed):

Street Address: ______________________ City: _________________ State: ________ ZIP Code: _________

Your Medicare Information

Medicare Number ____ ____ ____ - ____ ____ ____ - ____ ____ ____ _____

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to El Paso Health Advantage Dual SNP? ☐ 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 El Paso Health Advantage Dual SNP (HMO D-SNP).
- By joining this Medicare Advantage Plan, I acknowledge that El Paso Health Advantage Dual SNP (HMO D-SNP) 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 El Paso Health Advantage Dual SNP (HMO D-SNP) coverage begins, I must get all of my medical and prescription drug benefits from El Paso Health. Benefits and services provided by El Paso Health and contained in my El Paso Health Advantage Dual SNP (HMO D-SNP) "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor El Paso Health will pay for benefits or services that are not covered.
- El Paso Health Advantage Dual SNP (HMO D-SNP) serves a specific service area. If I move out of the area that El Paso Health Advantage Dual SNP (HMO D-SNP) 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 El Paso Health Advantage Dual SNP (HMO D-SNP), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from El Paso Health Advantage Dual SNP (HMO D-SNP) when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare are not usually covered under Medicare while out of the country except for limited coverage near the U.S. border.
- 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 below 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 can't be denied coverage because you don't fill them out.

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

☐ Spanish

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

☐ Braille ☐ Large print

Please contact El Paso Health Advantage Dual SNP at 1-833-742-3125 if you need information in an accessible format other than what's listed above. Our office hours are 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31, and Monday through Friday April 1 through September 30, Monday through Friday, 8:00 a.m. to 8:00 p.m. . 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:

Please select a premium payment option:

☐ Get a bill

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/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.)

Please Read This Important Information

If you currently have health coverage from an employer or union, joining El Paso Health Advantage Dual SNP (HMO D-SNP) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join El Paso Health Advantage Dual SNP (HMO D-SNP). Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is not any information on whom to contact, your benefits administrator or the office that answers, questions about your coverage can help.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with El Paso Health Advantage Dual SNP (HMO D-SNP), he/she may be paid based on my enrollment in El Paso Health Advantage Dual SNP (HMO D-SNP).

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): ______________________________

Agent/Broker ID#: __________________________

Plan ID#: ___________________________________

Effective Date of Coverage: __________________

ICEP/IEP: _________ AEP:_________SEP (type):_________

Privacy Act Statement

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this 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 was recently 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 got 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 got 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 have not 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 plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) ______________________________.

☐ 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.

If none of these statements applies to you or you're not sure, please contact El Paso Health Advantage Dual SNP (HMO D-SNP)at 1-833-742-3125 (TTY users should call 711) to see if you are eligible to enroll. We are open 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31, and Monday through Friday April 1 through September 30, Monday through Friday, 8:00 a.m. to 8:00 p.m.