El Paso Health+
Advantage Dual SNP

MODEL 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 January1)
- 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 planmust 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:
El Paso Health Advantage Dual SNP
P.O. Box 971100
El Paso, TX 79997-1100
Or by fax at: 915-532-2286

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

How do I get help with this form?

Call El Paso Health Advatnge Dual at 1-833-742-3125. TTY users can call 711.

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

En español: Llame a El Paso Health Advantage Dual SNP al 1-833-742-3125/TTY 711 o a Medicare gratis al 1-800-633-4227 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) maybe considered your permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

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

Select the plan you want to join:
☐ El Paso Health Advantage Dual SNP (HMO D-SNP) – $0.00 per month

FIRST name: LAST name: Optional: Middle Inital:

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

Permanent Residence street address (Don't enter a PO Box):

City: County: State: Zip Code:

Mailing address, if different from your permanent 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 (HMO D-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", write 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, 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.
- 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 (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my El Paso Health Advantage Dual SNP (HMO D-SNP) coverage beings, I must get all of my medical and prescription drug benefits from El Paso Health Advantage Dual. Benefits and services provided by El Paso Health Advantage Dual SNP (HMO D-SNP) and contained in my El Paso Health Advantage Dual SNP "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor El Paso Health Advantage Dual SNP (HMO D-SNP) will pay for benefits or services not covered.
- 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 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 perosn 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 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, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Lationo/a, or Spanish origin
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

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

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 ☐ Audio CD

Please contact El Paso Health Dual Advantage SNP (HMO D-SNP) at 1-833-742-3125 if you need information in an accessible format other than what's listed above. Our office hours are October 1–March 31, 8 a.m. to 8 p.m., 7 days a week and April 1– September 30, 8 a.m. to 8 p.m., Monday to Friday. 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:

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

☐ Evidence of Coverage ☐ Formulary

☐ Pharmacy Directory ☐ Summary of Benefits

☐ Provider Directory

E-mail address:

Paying your plan premiums

☐ 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 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.)

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:

☐ IEP/ICEP ☐ AEP ☐ OEP ☐ SEP (type): _____

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

Agent/Broker ID#: _____

Effective Date of Coverage: _____

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.