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

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?

Send your completed and signed form to:

Centers Plan for Healthy Living
75 Vanderbilt Avenue
Staten Island, NY 10304

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

How do I get help with this form?

Call Centers Plan for Healthy Living at 1-877-940-9330. 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 Centers Plan for Healthy Living al 1-877-940-9330/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. Los usuarios de TTY pueden llamar 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.

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.

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

Select the plan you want to join:

- ☐ Centers Plan for Medicare Advantage Care (HMO) — $0.00 per month
- ☐ Centers Plan for Dual Coverage Care (HMO D-SNP) — $48.70 per month
- ☐ Centers Plan for Nursing Home Care (HMO I-SNP) — $48.70 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 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 Centers Plan for Healthy Living? ☐Yes ☐No

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

For People with Medicare and Medicaid ONLY: Are you enrolled in your State Medicaid program?
☐Yes ☐No

If yes, please provide your Medicaid number: ______________________

For I-SNP ONLY: Are you a resident in a long-term care facility, such as a nursing home? ☐Yes ☐No
If yes, please provide the following information:

Name of the institution: ____

Address: ____

Telephone number: ______________________________________

Admission date: ___/___/______

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Centers Plan for Healthy Living.
- By joining this Medicare Advantage, I acknowledge that Centers Plan for Healthy Living 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 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 Centers Plan for Healthy Living coverage begins, I must get all of my medical and prescription drug benefits from Centers Plan for Healthy Living. Benefits and services provided by Centers Plan for Healthy Living and contained in my Centers Plan for Healthy Living "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Centers Plan for Healthy Living 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:

Office/Agent/Broker Use ONLY:

Name of Agent/Broker (if assisted with enrollment) ____

Phone number of Agent/Broker (if assisted with enrollment): __________________________________

Plan Contract: H6988 PBP: ________ Enrollment Effective Date: _______________________

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, Latino/a, or Spanish origin
☐ **I choose not to answer.**

What's your race? Select all that apply.

☐American Indian or Alaska Native

Asian:
☐Asian Indian
☐Chinese
☐Filipino
☐Japanese
☐Korean
☐Vietnamese
☐Other Asian

☐Black or African American

Native Hawaiian and Pacific Islander:
☐ Guamanian or Chamorro
☐ Native Hawaiian
☐Samoan
☐Other Pacific Islander

☐White
☐**I choose not to answer**

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

☐Spanish ☐Chinese ☐Other: ___________________________

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

☐Braille ☐Large print ☐Audio CD

Please contact Centers Plan for Healthy Living at 1-877-940-9330 if you need information in an accessible format other than what's listed above. Our office hours are 8 am-8 pm, 7 days a week. 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:

Name:

Address:

Phone number:

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

☐ Evidence of Coverage ☐ Pharmacy Directory

☐ Provider Directory ☐ Comprehensive Formulary (Drug List)

E-mail address: ____

Please contact Centers Plan for Healthy Living at 1-877-940-9330 if you want to get one of these materials by email. Our office hours are 8 am-8 pm, 7 days a week. TTY users can call 711.

Emergency Contact:

Name: ____________________ Phone Number: ____________________ Relationship to You: ____________________

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 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. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Centers Plan for Healthy Living the Part D-IRMAA.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Get a bill

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

☐SSA ☐RRB

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.