FHCP Medicare

OMB No. 0938-1378 Expires: 07/31/2024

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

You must complete all items unless they are indicated as optional. You can't be denied coverage for not including information that is marked as optional.

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.

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:

FHCP Medicare
P.O. Box 45296
Jacksonville, FL 32232-5296

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

How do I get help with this form?

Call FHCP Medicare Rx, FHCP Medicare Rx Plus or FHCP Medicare Rx Plus POS at 1-800-352-9824, Ext. 7160. TTY users can call 1-800-955-8770.

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

En español: Llame a FHCP Medicare Rx, FHCP Medicare Rx Plus o FHCP Medicare Rx Plus POS al 1-800-352-9824, Ext. 7160 / TTY: 1-800-955-8773 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

FHCP Medicare

P.O. Box 45296 | Jacksonville, FL 32232-5296

A Medicare Advantage Health Care Plan

Individual Enrollment Form

Please check which plan you want to enroll in:

- ○ **FHCP Medicare Rx** $0 per month
- ○ **FHCP Medicare Rx Plus** $49 per month
- ○ **FHCP Medicare Rx Plus POS** $119 per month

First Name: Last Name: Middle Initial:

Birth Date:	Sex:	Home Phone Number:	Alternate Phone Number:
M M D D Y Y Y Y	○ M ○ F	( )	( )

Permanent Residence Street Address (P.O. Box is not allowed):

City:	County:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):

Street Address:	City:	State:	ZIP Code:

Please provide your Medicare insurance information:

Please take out your red, white and blue Medicare card to complete this section.

Medicare Number:	Part A Effective Date:	Part B Effective Date:
	M M D D Y Y Y Y	M M D D Y Y Y Y

By providing the information above, you consent to receive calls and text messages (SMS/MMS) about your account, care, and non-marketing related calls to the number(s) provided from Florida Blue, DBA FHCP Medicare, its affiliates, and others acting on their behalf made to that phone number including calls and texts to your wireless device which may include an automated telephone dialing system and other related automated technologies, a prerecorded or artificial voice message, or both without regard to state or federal limitations on the frequency of calls or messages. If you do not wish to receive autodialed, prerecorded, or artificial voice calls to your mobile number, please contact us at 1-800-352-9824, Ext. 7160.

Ethnicity and Race (Optional)

Are you of 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

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format: ○ Spanish ○ Braille ○ Audio ○ Large print

Please contact FHCP Medicare Rx, FHCP Medicare Rx Plus or FHCP Medicare Rx Plus POS at 1-800-352-9824, Ext. 7160 if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. – 5 p.m. local time, Monday through Friday. TTY users should call 1-800-955-8770.

Please read and answer these important questions (Questions 2–5 are optional):

1. Will you have other **prescription** drug coverage (like VA, TRICARE) in addition to FHCP Medicare Rx, FHCP Medicare Rx Plus or FHCP Medicare Rx Plus POS? ○ Yes ○ No

   Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

2. Are you a resident in a long-term care facility, such as a nursing home? ○ Yes ○ No

   Name of Institution: _____ Phone Number: (_____) _____ – _____

   Address (number and street): _____

3. Are you enrolled in your State Medicaid program? ○ Yes ○ No

   Medicaid number: _____

4. Do you or your spouse work? ○ Yes ○ No

5. Please choose the name of a Primary Care Physician (PCP), clinic or health center: _____

Paying Your Plan Premium:

- **For those members enrolling in FHCP Medicare Rx,** if we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it.
- **For those members enrolling in FHCP Medicare Rx Plus or FHCP Medicare Rx Plus POS,** you can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT), or Credit Card each month. We need to know how you would prefer to pay.

Please select a premium payment option (If you don't select a payment option, you will get a bill each month):

○ Get a bill

○ Electronic Funds Transfer (EFT) from your bank account each month. (FHCP Medicare will send you a letter with further instructions on how to set this up.)

○ Credit Card (FHCP Medicare will send you a letter with further instructions on how to set this up.)

○ 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.)

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 FHCP Medicare the Part D-IRMAA.

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): |M|M| |D|D| |Y|Y|Y|Y|
- ○ I recently was released from incarceration. I was released on (insert date): |M|M| |D|D| |Y|Y|Y|Y|
- ○ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date): |M|M| |D|D| |Y|Y|Y|Y|
- ○ I recently obtained lawful presence status in the United States. I got this status on (insert date): |M|M| |D|D| |Y|Y|Y|Y|
- ○ 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): |M|M| |D|D| |Y|Y|Y|Y|
- ○ 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): |M|M| |D|D| |Y|Y|Y|Y|
- ○ 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 (insert date): |M|M| |D|D| |Y|Y|Y|Y|
- ○ I recently left a PACE program on (insert date): |M|M| |D|D| |Y|Y|Y|Y|
- ○ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date): |M|M| |D|D| |Y|Y|Y|Y|
- ○ I am leaving employer or union coverage on (insert date): |M|M| |D|D| |Y|Y|Y|Y|
- ○ 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): |M|M| |D|D| |Y|Y|Y|Y|
- ○ 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): |M|M| |D|D| |Y|Y|Y|Y|
- ○ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- ○ I was 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 was enrolled in a plan identified with the low performing icon (LPI).

If none of these statements applies to you or you're not sure, please contact FHCP Medicare Rx, FHCP Medicare Rx Plus or FHCP Medicare Rx Plus POS at 1-800-352-9824, Ext. 7160 (TTY users should call 1-800-955-8770) to see if you are eligible to enroll. We are open 8 a.m. – 5 p.m. local time, Monday through Friday.

Please 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 FHCP Medicare Rx, FHCP Medicare Rx Plus or FHCP Medicare Rx Plus POS.
- I understand that my 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).
- 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 FHCP Medicare Rx, FHCP Medicare Rx Plus or FHCP Medicare Rx Plus POS coverage begins, I must get all of my medical and prescription drug benefits from FHCP Medicare Rx, FHCP Medicare Rx Plus or FHCP Medicare Rx Plus POS. Benefits and services provided by FHCP Medicare Rx, FHCP Medicare Rx Plus or FHCP Medicare Rx Plus POS and contained in my FHCP Medicare Rx, FHCP Medicare Rx Plus or FHCP Medicare Rx Plus POS "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor FHCP Medicare Rx, FHCP Medicare Rx Plus or FHCP Medicare Rx Plus POS will pay for benefits or services that are not covered.
- **Release of Information:** By joining this Medicare health plan, I acknowledge that FHCP Medicare Rx, FHCP Medicare Rx Plus or FHCP Medicare Rx Plus POS will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.

  I also acknowledge that FHCP Medicare Rx, FHCP Medicare Rx Plus or FHCP Medicare Rx Plus POS 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).
- I understand that my signature (or the signature of the person legally authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (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: M M D D Y Y Y Y

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: (_____) _____ – _____ **Relationship to Enrollee:** _____

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 and 1860D-1 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.

Text Messages

Text messages are a great way to stay in touch, manage your account, and learn more about your plan and benefits.

We may send you a confirmation text message after you are enrolled to complete your registration to receive member messages and alerts. By opting in, you consent to receive text messages which may include but not be limited to financial matters and marketing from Florida Blue, DBA FHCP Medicare, its affiliates, and others acting on their behalf. This may include an automated technologies without regard to state or federal limitations on the frequency of calls or messages. I understand that my consent is not required as a condition of making a purchase. Message frequency varies and message and data rates may apply. These communications may contain Protected Health Information (PHI) that is protected by applicable law and by opting-in you agree and understand that communications may be unencrypted, and you agree to accept the risk that unencrypted electronic communications may be intercepted and/or read by a third party. You can cancel the SMS service for subscribed messages at any time.

○ **I want to receive text messages and alerts and agree to the terms and conditions stated and referenced above.**

Mobile Number: (_____) _____ – _____

Email Communications

Email is a great way to stay in touch. Enter your email below to opt-in to receive email messages. By enrolling in paperless communications, you agree to receive messages electronically, which may include but not limited to, the Evidence of Coverage, Summary of Benefits, Notice of Privacy Practices, Proxy Statements, financial matters, and marketing. You understand and acknowledge that electronic communications may not be secure, you are responsible for and accept the risk you agree to accept the risk that electronic communications may be intercepted and/or read by a third party. By agreeing to receive electronic communications you agree to indemnify and hold Florida Blue, DBA FHCP Medicare and its affiliates harmless from any claim or cause of action against Florida Blue, DBA FHCP Medicare and its affiliates for delivering or other information to the address, phone number, or other contact information that you provide.

E-mail: _____

Office Use Only:	
Name of staff member/agent/broker (if assisted in enrollment): _____	Entity Name: _____
Plan ID #: _____	Five digit Entity ID number (if known): _____
Effective Date of Coverage: _____	Date Received by Agent: _____
ICEP/IEP: _____	FHCP Medicare Agent ID #: _____
AEP: _____	Agent State License #: _____
SEP (type): _____	Agent Confirmation #: _____
Not Eligible: _____	
PCP Provider ID#: _____	