



## 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](https://www.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

## 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 Choice 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 Choice al 1-800-352-9824, Ext. 7160 / TTY: 1-800-955-8770 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.



**have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay FHCP Medicare the Part D-IRMAA.**

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at [www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.gov/prescriptionhelp).

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

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

**Please select a premium payment option:**

- 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.)

**Please read and answer these important questions:**

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other **prescription** drug coverage in addition to FHCP Medicare Choice?  Yes  No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

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

If "yes," please provide the following information:

Name of Institution: \_\_\_\_\_

Address & Phone Number of Institution (number and street): \_\_\_\_\_

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

If "yes," please provide your Medicaid number: \_\_\_\_\_

4. Do you or your spouse work?  Yes  No

**Please choose the name of a Primary Care Physician (PCP), clinic or health center:** \_\_\_\_\_

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 tape  Large print

Please contact FHCP Medicare Choice 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. Monday through Friday. TTY users should call 1-800-955-8770.



## Please Read This Important Information

If you currently have health coverage from an employer or union, joining FHCP Medicare Choice could affect your employer or union health benefits. You could lose your employer or union health coverage if you join FHCP Medicare Choice. 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 isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

### 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): MMDDYYYY
- I recently was released from incarceration. I was released on (insert date): MMDDYYYY
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date): MMDDYYYY
- I recently obtained lawful presence status in the United States. I got this status on (insert date): MMDDYYYY
- 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): MMDDYYYY
- 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): MMDDYYYY
- 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): MMDDYYYY
- I recently left a PACE program on (insert date): MMDDYYYY
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date): MMDDYYYY

- 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.
- 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 Choice 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 understand that my response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

FHCP Medicare Choice is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 - December 7 of every year), or under certain special circumstances.

FHCP Medicare Choice serves a specific service area. If I move out of the area that FHCP Medicare Choice 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 FHCP Medicare Choice, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from FHCP Medicare Choice 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 aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date FHCP Medicare Choice coverage begins, I must get all of my health care from FHCP Medicare Choice, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by FHCP Medicare Choice and other services contained in my FHCP Medicare Choice Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR FHCP MEDICARE CHOICE WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with FHCP Medicare Choice, he/she may be paid based on my enrollment in FHCP Medicare Choice.

**Release of Information:** By joining this Medicare health plan, I acknowledge that FHCP Medicare Choice 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 Choice will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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 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
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If you are the authorized representative, you must sign above and provide the following information:

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** [ ][ ][ ][ ] [ ][ ][ ][ ] [ ][ ][ ][ ][ ]

**Relationship to Enrollee:** \_\_\_\_\_

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