OMB No. 0938-1378 Expires: 07/31/2023

FHCP Medicare

## 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

## 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 Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor 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 Savings, FHCP Medicare Premier Advantage, o FHCP Medicare Valor 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.

FHCP Medicare

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

**A Medicare Advantage Health Care Plan**

# Individual **Enrollment Form**

FHCP Medicare **Rx Savings** (HMO)
FHCP Medicare **Valor** (HMO)

FHCP Medicare **Premier Advantage** (HMO)

Please contact FHCP Medicare Rx Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor if you need information in another language or format (Braille).

**To Enroll in FHCP Medicare Rx Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor please provide the following information:**

**Please check which plan you want to enroll in:**

- ○ FHCP Medicare **Rx Savings** (HMO) $0 per month
- ○ FHCP Medicare **Valor** (HMO) $0 per month
- ○ FHCP Medicare **Premier Advantage** (HMO) $0 per month

| Last Name: | First Name: | Middle Initial: | ○ Mr. ○ Mrs. ○ Ms. |
|---|---|---|---|
| Birth Date: M M D D Y Y Y Y | Sex: ○ M ○ F | Home Phone Number: ( ) | Alternate Phone Number: ( ) |

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: |
|---|---|---|---|

E-mail Address:

**Please provide your Medicare insurance information:**

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

- Fill out this information as it appears on your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled To — Effective Date

**HOSPITAL (PART A)** _____

**MEDICAL (PART B)** _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

## Paying Your Plan Premium

**For those members enrolling in FHCP Medicare Rx Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor,** 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. You can pay by mail, Electronic Funds Transfer (EFT), or Credit Card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either 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.**

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 Rx Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor? ○ 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 ○ Large print

Please contact FHCP Medicare Rx Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor 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.

## STOP Please Read This Important Information

**If you currently have health coverage from an employer or union, joining FHCP Medicare Rx Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor could affect your employer or union health benefits. You could lose your employer or union health coverage if you join FHCP Medicare Rx Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor.** 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): |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)). 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 Rx Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor 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 Rx Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor 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 Rx Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor serves a specific service area. If I move out of the area that FHCP Medicare Rx Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor 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 Rx Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor, 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 Rx Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor 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 Rx Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor coverage begins, I must get all of my health care from FHCP Medicare Rx Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by FHCP Medicare Rx Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor and other services contained in my FHCP Medicare Rx Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR FHCP MEDICARE RX SAVINGS, FHCP MEDICARE PREMIER ADVANTAGE, OR FHCP MEDICARE VALOR 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 Rx Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor, he/she may be paid based on my enrollment inFHCP Medicare Rx Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor.

**Release of Information:** By joining this Medicare health plan, I acknowledge that FHCP Medicare Rx Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor 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 Savings, FHCP Medicare Premier Advantage, or FHCP Medicare Valor 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|

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

**Name:** _____

**Address:** _____

**Phone Number:** |_|_|_| - |_|_|_| - |_|_|_|_|

**Relationship to Enrollee:** _____

## Office Use Only:

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

_____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____

AEP: _____

SEP (type): _____

Not Eligible: _____

PCP Provider ID#: _____

Entity Name:

_____

Five digit Entity ID number (if known):

|_|_|_|_|_|

Date Received by Agent: _____

FHCP Medicare Agent ID #: _____

Agent State License #: _____

Agent Confirmation #: _____