OMB No. 0938-1378 Expires: 7/31/2023

Commonwealth Care Alliance 2022 Medicare Advantage Enrollment Form

MASSACHUSETTS

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:

Commonwealth Care Alliance
30 Winter Street
Boston, MA 02108

Once we process your request to join, we will contact you.

How do I get help with this form?

- Call Commonwealth Care Alliance at 866-265-7050. 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 Commonwealth Care Alliance al 866-265-7050/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.

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.

SECTION 1: All fields required unless labeled as optional

First name:

Middle initial: (optional)

Last name:

Title: (optional)

◯ Mr. ◯ Mrs. ◯ Ms.

Gender:

◯ M ◯ F

Birth date: (mm/dd/yyyy)

Primary phone number:

Alternate phone number: (optional)

Email address: (optional)

Permanent residence street address: (do not enter a P.O. box)

City:

State:

Zip code:

Mailing address, if different from your permanent address: (P.O. box allowed)

City:

State:

Zip code:

Emergency contact: (optional)

Phone number: (optional)

Relationship to you: (optional)

Select the plan you want to join

The chart below shows available plans in our service area and standard monthly plan premiums **(in bold). Please select ONE plan.**

Massachusetts Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, Worcester counties	**Plan Premium**
◯ CCA Medicare Preferred (PPO)	**$0/month**
◯ CCA Medicare Value (PPO)	**$36.30/month**

Requested effective date: (mm/dd/yyyy, must be in the future)

Your Medicare 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 letter from Social Security or the Railroad Retirement Board.

Name as it appears on your Medicare card: (optional)

Medicare number:

Is entitled to:

HOSPITAL (Part A) **Effective date:** (mm/dd/yyyy; optional)

MEDICAL (Part B) **Effective date:** (mm/dd/yyyy; optional)

Answer these important questions

1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Commonwealth Care Alliance plan? **If yes,** please list your other coverage and your member and group numbers for this coverage.

   ◯ Yes
   ◯ No

   Name of other coverage:

   Member number for this coverage:

   Group number for this coverage:

2. **OPTIONAL:** Are you a resident in a long-term care facility, such as a nursing home? **If yes**, please provide the following information and see question 5 on the following page.

   ◯ Yes
   ◯ No

   Name of institution:

   Phone number:

   Street address:

   City:

   State:

   Zip code:

3. **OPTIONAL:** Are you enrolled in your State Medicaid program? (In Massachusetts, this is called "MassHealth.") **If yes**, please provide your Medicaid number.

   ◯ Yes
   ◯ No

   Medicaid (MassHealth) number:

Please select eligibility for 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. Please select **one** statement.

☐ 1. Annual Enrollment Period (AEP). Your plan effective date will be January 1.

☐ 2. I am new to Medicare.

☐ 3. I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) from January 1 through March 31.

☐ 4. 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: (mm/dd/yyyy)

☐ 5. 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). If you currently reside in a long-term care facility, please answer question 2 on the previous page.

I moved on: (mm/dd/yyyy)

☐ 6. I am leaving employer or union coverage.

I will leave this coverage on: (mm/dd/yyyy)

☐ 7. I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid).

I had this change on: (mm/dd/yyyy)

☐ 8. 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*).

I had this change on: (mm/dd/yyyy)

☐ 9. 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.

☐ 10. I recently returned to the United States after living permanently outside of the U.S.

I returned to the U.S. on: (mm/dd/yyyy)

☐ 11. I recently obtained lawful presence in the United States.

I got this status on: (mm/dd/yyyy)

☐ 12. I recently was released from incarceration.

I was released on: (mm/dd/yyyy)

☐ 13. I recently left a PACE program.

I left this program on: (mm/dd/yyyy)

☐ 14. I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).

I lost my drug coverage on: (mm/dd/yyyy)

☐ 15. I belong to a pharmacy assistance program provided by my state.

☐ 16. My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ 17. 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: (mm/dd/yyyy)

☐ 18. 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 this SNP on: (mm/dd/yyyy)

☐ 19. 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.

☐ Other reason: (please describe Special Election Period)

If none of these statements apply to you or you're not sure, *please contact Commonwealth Care Alliance at 866-265-7050 (TTY users should call 711) to see if you are eligible to enroll. We are open 7 days a week, 8 a.m.–8 p.m. (From April 1–September 30: Monday through Friday, 9 a.m.–6 p.m.)*

IMPORTANT: Read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in a Commonwealth Care Alliance Medicare plan.
- By joining this Medicare Advantage Plan, I acknowledge that Commonwealth Care Alliance 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.*
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- Sales agents may be compensated if they are helping the individual to enroll.
- 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 Commonwealth Care Alliance coverage begins, I must get all of my medical and prescription drug benefits from Commonwealth Care Alliance. Benefits and services provided by Commonwealth Care Alliance and contained in my Commonwealth Care Alliance "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Commonwealth Care Alliance 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: (mm/dd/yyyy)

If you're the authorized representative, sign above and fill out these fields.

Full name:

Street address:

City:

State:

Zip code:

Phone number: (optional)

Relationship to enrollee:

SECTION 2: All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage if you don't fill them out.

Preferred written language:

Preferred spoken language:

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 Commonwealth Care Alliance at **1-866-610-2273** if you need information in an accessible format or language other than what is listed above. Our office hours are 7 days a week, 8 a.m.–8 p.m. (April 1–September 30: Monday through Friday, 8 a.m.–8 p.m.) TTY users can call **711**.*

Please choose a Commonwealth Care Alliance contracted primary care physician (PCP):

If you don't list a PCP here, we will automatically assign one to you. You can change your PCP at any time after you enroll.

PAYING YOUR PLAN PREMIUM

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) 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 Commonwealth Care Alliance the Part D-IRMAA.

- **If you don't select a payment option, you will get a bill each month.**
- **If you select a plan with $0 premium payment, you do not need to select a payment option.**

Please select a premium payment option:

◯ **Get a bill each month. You may remit by check**

◯ **Automatic payments by EFT including ACH Debit or Credit Cards.**
(If this option is selected, you will receive information on how to pay by these methods in our payment platform once enrolled.)

◯ **Automatic deduction from your monthly Social Security benefit check.**

◯ **Automatic deduction from your monthly Railroad Retirement Board (RRB) benefit check.**
The Social Security/RRB deduction may take two or more months to begin. There may be a delay in withholding your premium due to the Social Security Administration's monthly processing schedule, as the start date of premium withholding cannot be retroactive. If there is a delay, you will be billed directly for the first 1–2 months until your premium is deducted from your Social Security or RRB benefit check. You are responsible for paying all premiums due until premium withholding begins. If you do not pay your premium for the month(s) before premium withholding begins, you may be disenrolled from Commonwealth Care Alliance. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

OFFICE/BROKER USE ONLY

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

Agent NPN:

Date application received: (mm/dd/yyyy)

Effective date of coverage: (mm/dd/yyyy)

Enrollment period:

◯ ICEP/IEP ◯ AEP ◯ OEP ◯ SEP (type:)

◯ Not eligible