

# CCA One Care 2026 Enrollment Form

OMB No. 0938-1378

Expires: 12/31/2026



## Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug 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

**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.
- \$0 premium<sup>1</sup>

## What happens next?

Send your completed and signed form to:

**Commonwealth Care Alliance, Inc.**  
**2 Avenue de Lafayette, 5th Floor**  
**Boston, MA 02110**

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

## How do I get help with this form?

Call CCA One Care (HMO D-SNP) at 855-210-1659. 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 CCA One Care (HMO D-SNP) al 855-210-1659 (TTY 711) o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

## 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.

<sup>1</sup>You must continue to pay your Medicare Part B premium unless it is being paid on your behalf by MassHealth.

CCA One Care (HMO D-SNP) is a health plan that contracts with both Medicare and MassHealth (Medicaid) to provide benefits of both programs to enrollees. Enrollment in the plan depends on the plan's contract renewal with Medicare. This plan is a voluntary program that is available to anyone age 21 - 64 who qualifies for MassHealth Standard or Commonwealth and Original Medicare and does not have any other comprehensive health insurance, except Medicare.

# CCA One Care 2026 Enrollment Form

OMB No. 0938-1378 Expires: 12/31/2026



| Section 1 – All fields on this page are required (unless marked optional)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                       |                                             |                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------|-----------------|
| Select the plan you want to join: <input type="checkbox"/> CCA One Care (HMO D-SNP)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                       |                                             |                 |
| FIRST name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                       | LAST name:                                  | Middle initial: |
| Birth date: (MM/DD/YYYY)<br>(__/__/____)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Sex:<br><input type="checkbox"/> Male <input type="checkbox"/> Female | Phone number:<br>( )<br>Cell number:<br>( ) |                 |
| Permanent residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                       |                                             |                 |
| City:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                       | State:                                      | ZIP Code:       |
| Mailing address, if different from your permanent address (PO Box allowed):<br>Street address:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                       |                                             |                 |
| City:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                       | State:                                      | ZIP Code:       |
| Your Medicare Information:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                       |                                             |                 |
| Medicare Number: _____ - _____ - _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                       |                                             |                 |
| Your MassHealth (Medicaid) Information:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                       |                                             |                 |
| MassHealth Number: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                       |                                             |                 |
| Answer these important questions:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                       |                                             |                 |
| Will you have other prescription drug coverage (like VA, TRICARE) in addition to CCA One Care?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                       |                                             |                 |
| Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                       |                                             |                 |
| To qualify, you must be between the ages of 21 and 64, have a disability, have MassHealth Standard or CommonHealth, Medicare Parts A and B, and qualify for Medicare Part D. You must live in the plan area, cannot be part of a Home and Community Based Services (HCBS) Waiver, and have no other comprehensive health insurance. To apply for MassHealth, call 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled). If you require assistance, please contact CCA at 855-210-1659 (TTY: 711) 7 days a week, 8 am – 8 pm (From April 1 – September 30: Monday through Friday, 8 am – 8 pm). |                                                                       |                                             |                 |

| <b>IMPORTANT: Read and sign below:</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| <b>By completing this enrollment application, I agree to the following:</b>                                                                                                                                                                                                                                                                                                                                                                               |                           |
| I must keep both Hospital (Part A) and Medical (Part B) to stay in CCA One Care.                                                                                                                                                                                                                                                                                                                                                                          |                           |
| By joining this Medicare Advantage Plan, I acknowledge that CCA One Care 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 in 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 or Part D plan at a time - and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).                                                                                                                                                                                                                            |                           |
| I understand that when my CCA One Care coverage begins, I must get all of my medical and prescription drug benefits from CCA One Care. Benefits and services provided by CCA One Care and contained in my CCA One Care "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CCA One Care will pay for benefits or services that are not covered.                               |                           |
| 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 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. |                           |
| <b>Signature:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>Today's date:</b>      |
| <b>If you're the authorized representative, sign above and fill out these fields:</b>                                                                                                                                                                                                                                                                                                                                                                     |                           |
| Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Address:                  |
| Phone number:                                                                                                                                                                                                                                                                                                                                                                                                                                             | Relationship to enrollee: |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Section 2 – All fields in this section are optional</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Answering these questions is your choice.<br/>You can't be denied coverage because you don't fill them out.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                    |
| Select one if you want us to send you information in a language other than English.<br><input type="checkbox"/> Spanish                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                    |
| Select one if you want us to send you information in an accessible format.<br><input type="checkbox"/> Braille <input type="checkbox"/> Large print <input type="checkbox"/> Audio CD <input type="checkbox"/> Data CD                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                    |
| Please contact CCA One Care at 866-610-2273 if you need information in an accessible format other than what's listed above. Our office hours are 8 am to 8 pm, 7 days a week. TTY users can call 711.                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                    |
| Do you work? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Does your spouse work? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                    |
| List your Primary Care Physician (PCP), clinic, or health center:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                    |
| E-mail address:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>For individuals helping enrollee with completing this form only</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                    |
| Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                    |
| Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Relationship to enrollee:                                                                                                                                                                                                                                                                                                                                                          |
| Signature:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | National Producer Number (Agents/Brokers only):                                                                                                                                                                                                                                                                                                                                    |
| <b>Agent/Broker use only. Agent/Broker must complete.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                    |
| Initial receipt date:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Proposed effective date:                                                                                                                                                                                                                                                                                                                                                           |
| <input type="checkbox"/> SEP (Once per month integrated care SEP for dually eligible individuals)<br><input type="checkbox"/> IEP (New to Medicare)<br><input type="checkbox"/> IEP2 (Had Medicare prior, but now turning 65)<br><input type="checkbox"/> ICEP (Had Part A and recently signed up for Part B)<br><input type="checkbox"/> AEP (Annual Election Period)<br><input type="checkbox"/> OEP (In a Med Adv Plan and want to change; Jan 1 – Mar 31)<br><input type="checkbox"/> OEP (In a Med Adv Plan < 3 mos. and want to change; Apr 1 – Dec 31)                                                                                                             | <input type="checkbox"/> OEPI (Live in an LTC facility)<br><input type="checkbox"/> OEPI (Moving out of an LTC facility)<br><input type="checkbox"/> SEP (Recent change in Medicaid)<br><input type="checkbox"/> SEP (Recent change in Extra Help paying for prescriptions)<br><input type="checkbox"/> SEP (Left employer coverage)<br><input type="checkbox"/> SEP (Other _____) |
| <b>PRIVACY ACT STATEMENT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                    |
| 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. |                                                                                                                                                                                                                                                                                                                                                                                    |

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 page 1 to send your completed form to the plan.**