

# 2023

## INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)



### 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

**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:

CCA Health Michigan  
23900 Orchard Lake Road  
Farmington Hills, MI 48336

Or online at [www.app-ccahealthmi.org/enroll-now](https://www.app-ccahealthmi.org/enroll-now)

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

### How do I get help with this form?

Call CCA Health Michigan at 833-833-0702. 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 Health Michigan al 833-833-0702 o 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.

### 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.

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 this page to send your completed form to the plan.

**Section 1 – All fields on this page are required (unless marked optional)**

**Select the plan you want to join:**

- |  |  |
|--|--|
| <input type="checkbox"/> CCA Medicare Excel (HMO)      \$0 per month         | <input type="checkbox"/> CCA Medicare Ultima (HMO)      \$40 per month |
| <input type="checkbox"/> CCA Medicare Maximum (HMO D-SNP)      \$0 per month |  |

FIRST name: \_\_\_\_\_ LAST name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Birth date: (MM/DD/YYYY) (__ / __ / _____)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone number: (       )
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Permanent Residence street address (Don't enter a PO Box): \_\_\_\_\_

City: _____	State: _____	Zip Code: _____
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Mailing address, if different from your permanent address (PO Box allowed):

Street address: _____	City: _____	State: _____	Zip Code: _____
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**Your Medicare Information:**

**Medicare Number:**                      \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Answer these important questions:**

Will you have other prescription drug coverage (like VA, TRICARE) in addition to CCA Health Michigan?  
 Yes     No

Name of other coverage: \_\_\_\_\_ Member number for this coverage: \_\_\_\_\_ Group number for this coverage: \_\_\_\_\_

Are you enrolled in your State Medicaid program?\* (Required for enrollment in SNP Plans)

Yes     No    If "yes," please provide your Medicaid number: \_\_\_\_\_

**Important: Read and sign below:**

- I must keep both Hospital (Part A) and Medical (Part B) to stay in CCA Health Michigan.
- By joining this Medicare Advantage, I acknowledge that CCA Health Michigan 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 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).
- I understand that when my CCA Health Michigan coverage begins, I must get all of my medical and prescription drug benefits from CCA Health Michigan. Benefits and services provided by CCA Health Michigan and contained in my CCA Health Michigan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CCA Health Michigan 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> _____
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If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone Number:	Relationship to enrollee:
<b>Section 2 – All fields on this page are optional</b>	
Answering these questions is your choice. You can't be denied coverage because you don't fill them out.	
Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.	
<input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin <input type="checkbox"/> Yes, Mexican, Mexican America, Chicano/a <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin <input type="checkbox"/> <b>I choose not to answer</b>	
What's your race? Select all that apply.	
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black or African American <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> White <input type="checkbox"/> <b>I choose not to answer</b>	
Select one if you want us to send you information in a language other than English.	
<input type="checkbox"/> Spanish <input type="checkbox"/> Arabic	
Select one if you want us to send you information in an accessible format.	
<input type="checkbox"/> Braille <input type="checkbox"/> Large print <input type="checkbox"/> Audio CD	
Please contact CCA Health Michigan at <833-833-0702> TTY 711 if you need information in an accessible format other than what's listed above. Our office hours are <8am to 8pm, seven days a week from October 1 through March 31, and 8am to 8pm, Monday through Friday from April 1 through September 30>.	
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:	
I want to get the following materials via email. Select one or more.	
<input type="checkbox"/> Evidence of Coverage <input type="checkbox"/> Formulary <input type="checkbox"/> Provider Directory <input type="checkbox"/> Summary of Benefits	
Email address: _____	
<i>Member materials area available online at <a href="http://ccahealthmi.org">ccahealthmi.org</a></i>	
<b>Paying your plan premiums</b>	
You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. <b>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.</b>	
<b>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. DON'T pay CCA Health Michigan the Part D-IRMAA.</b>	

**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 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.

**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.

- |  |   |
|--|---|
| <p><input type="checkbox"/> I am enrolling during the Annual Enrollment Period (AEP) from October 15 to December 7.</p> <p><input type="checkbox"/> I am new to Medicare</p> <p><input type="checkbox"/> I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).</p> <p><input type="checkbox"/> 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 ____/____/____.</p> <p><input type="checkbox"/> I recently was released from incarceration. I was released on ____/____/____.</p> <p><input type="checkbox"/> I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ____/____/____.</p> <p><input type="checkbox"/> I recently obtained lawful presence status in the United States. I got this status on ____/____/____.</p> <p><input type="checkbox"/> I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on ____/____/____.</p> <p><input type="checkbox"/> 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 ____/____/____.</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> 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 ____/____/____.</p> | <p><input type="checkbox"/> I recently left a PACE program on ____/____/____.</p> <p><input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on ____/____/____.</p> <p><input type="checkbox"/> I am leaving employer or union coverage on ____/____/____.</p> <p><input type="checkbox"/> I belong to a pharmacy assistance program provided by my state.</p> <p><input type="checkbox"/> My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.</p> <p><input type="checkbox"/> 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 ____/____/____.</p> <p><input type="checkbox"/> I was enrolled in a Special Needs Plan (SNP) but I have the lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on ____/____/____.</p> <p><input type="checkbox"/> I was affected by a major disaster or other emergency 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 or other emergency.</p> <p><input type="checkbox"/> None of these statements apply to me.</p> |
|--|---|

If none of these statements apply to you or you're not sure, please contact CCA Health at <833-833-0702> (TTY users should call 711) to see if you are eligible to enroll. We are open <7 days a week, 8 am–8 pm (From April 1–September 30: Monday through Friday, 9 am–6 pm)>

**Office use only**

Staff Member/Agent/Broker Signature: \_\_\_\_\_ Agent/Broker ID#:

Date Accepted: \_\_\_\_\_ Source Code: \_\_\_\_\_ Location: \_\_\_\_\_

**Election Period:** ICEP/IEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP (type): \_\_\_\_\_

Scope of Appointment (required if not seminar):  Yes Seminar  No Seminar