OMB No. 0938-1378 Expires:7/31/2024



MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN ENROLLMENT FORM

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 January1)
- 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: CCA Health Rhode Island 3 Davol Square Suite C-300 Providence, RI 02903

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

How do I get help with this form?

Call CCA Health Rhode Island at 855-451-4905. 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 Rhode Island al 855-451-4905/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.

ndividuals 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.

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Section 1 – All fields o	n this page are rec	quired (u	ınless marked	optional)	
Select the plan you want to join:					
☐ CCA Medicare Preferred (PPO) - \$0 per month ☐ CCA Medicare Value (PPO) - \$29 per month					
FIRST name:	LAST name:			itial (optional):	
Birth date: (MM/DD/YYYY)	Sex:	Phone nu	ımber:		
Permanent Residence street address (D	☐ Male ☐ Female	()		
·	·			ZID C. 1	
City:	County (optional):		State:	ZIP Code:	
Mailing address, if different from your	•	O Box allo	,	ada.	
Street address: City: State: ZIP Code: Your Medicare information:					
Medicare Number:					
A	Answer these importar		ns:		
Will you have other prescription drug Name of other coverage:	Member number for th		-	ber for this coverage	
IMPORTANT: Read and sign below:					
 I must keep both Hospital (Part A) and Medical (Part B) to stay in CCA Medicare Advantage Plans. By joining this Medicare Advantage, I acknowledge that CCA Health Rhode Island 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 Rhode Island coverage begins, I must get all of my medical and prescription drug benefits from CCA Health Rhode Island. Benefits and services provided by CCA Health Rhode Island and contained in my CCA Health Rhode Island "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CCA Health Rhode Island 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: This person is authorized under State law to complete this enrollment, and Documentation of this authority is available upon request by Medicare. 					
Signature:		Γoday's da			
If you're the authorized representative			ds:		
Name:	l A	Address:			

Relationship to enrollee:

Phone number:

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Section 2 – All fields on	this page are optional			
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 to No, not of Hispanic, Latino/a, or Spanish origin Yes, Puerto Rican Yes, another Hispanic, Latino/a, or Spanish origin I choose not to answer.	hat apply. ☐ Yes, Mexican, Mexican American, Chicano/a ☐ Yes, Cuban			
What's your race? Select all that apply. American Indian or Alaska Native Asian Asian Indian Chinese Filipino Japanese Korean Vietnamese Other Asian Select one if you want us to send you information in a lar	□ Black or African American Native Hawaiian and Pacific Islander: □ Guamanian or Chamorro □ Native Hawaiian □ Samoan □ Other Pacific Islander □ White □ I choose not to answer.			
□ Spanish	iguage omer man Enghon.			
Select one if you want us to send you information in an accessible format. □ Braille □ Large print □ Audio CD Please contact CCA Health Rhode Island at 855-451-4905 if you need information in an accessible format other than what's listed above. Our office hours are 7 days a week, 8 am - 8 pm. TTY users can call 711.				
Do you work? ☐ Yes ☐ No	Does your spouse work? ☐ Yes ☐ No			
List your Primary Care Physician (PCP), clinic, or health of	center:			
Paying your plan premiums 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 automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you pay 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 RRB. DO NOT pay CCA the Part D-IRMAA. Would you like the premium for this plan deducted from your SSA or RRB monthly benefit check? □ Yes, Automatically deduct from my Social Security or Railroad Retirement Board (RRB) benefit check. I get my benefits from: □ Social Security □ Railroad Retirement Board				
Staff member/Agent/Broker use only: Name (if assisted in enrollment): Drongs	NPN#:ed effective date of coverage:			
Initial receipt date: Propos	ed effective date of coverage.			

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.

☐ 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//
☐ I recently was released from incarceration. I was released on/
\square I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on/
☐ I recently obtained lawful presence status in the United States. I got this status on//
☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on//
☐ 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/
☐ 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//

I recently left a PACE program on/
I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on//
I am leaving employer or union coverage on//
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 $_/_/_$
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//
I was affected by an emergency or major disaster (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.

If none of these statements applies to you or you're not sure, please contact CCA Health Rhode Island at 855-451-4905 (TTY users should call 711) to see if you are eligible to enroll. We are open 7 days a week, 8 am - 8 pm.