VILLAGECAREMAX

OMB No. 0938-1378
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INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C) OR MEDICARE PRESCRIPTION DRUG PLAN (PART D)

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)

Important: To join a Medicare Prescription Drug Plan, you must also have either, or 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:
VillageCareMAX
112 Charles Street
New York NY 10014

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

How do I get help with this form?

Call VillageCareMAX at 1-855-296-8800. 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 VillageCareMAX al 1-855-296-8800/711 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

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

Select the plan you want to join:

☐ VillageCareMAX Medicare Health Advantage Plan (HMO D-SNP): $0 – $58.80 per month

☐ VillageCareMAX Medicare Total Advantage Plan (HMO D-SNP): $0 – $58.80 per month

☐ VillageCareMAX Medicare Select Advantage Plan (HMO): $0 – $58.80 per month

FIRST name:	LAST name:	[Optional: Middle Initial]:

Birth date: (MM/DD/YYYY)	Sex:	Phone number:
(___ ___/___ ___/___ ___ ___ ___)	☐ Male ☐ Female	( )

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:	[Optional: County]:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):

Street address: City: State: ZIP Code:

Your Medicare information:

Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to VillageCareMAX?

☐ Yes ☐ No

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

_____ _____ _____

Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If yes, please provide your Medicaid number: _____

- VillageCareMAX Medicare Health Advantage Plan (HMO D-SNP): Please check if applicable ☐
  Are you eligible for Medicare cost-sharing assistance under New York State Medicaid?
- VillageCareMAX Medicare Total Advantage Plan (HMO D-SNP): Please check if applicable ☐
  Please indicate if you meet all the following requirements: 1) You are eligible for full New York State Medicaid coverage; 2) You are 18 years or older; and 3) you are eligible for nursing home level of care, and require community-based or facility-based Long Term Care Services for a continuous period of more than 120 days from the effective date of enrollment, based on an assessment completed by a registered nurse? 4) In need of Community Based Long Term Services and Supports (CBLTSS) for more than 120 days and meet the Minimum Needs Requirements as follows:
  - o At least limited assistance with physical maneuvering with more than two activities of Daily living (ADL); or Individuals with a Dementia or Alzheimer's diagnosis, at least supervision with more than one ADL.

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in VillageCareMAX.
- By joining this Medicare Advantage Plan, I acknowledge that VillageCareMAX 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 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 VillageCareMAX coverage begins, I must get all of my medical and prescription drug benefits from VillageCareMAX. Benefits and services provided by VillageCareMAX and contained in my VillageCareMAX "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor VillageCareMAX 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.

Signature:	Today's date:
If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

Section 2 – All fields in this section are optional

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

Select one if you want us to send you information in a language other than English.

☐ Spanish ☐ Spanish Creole ☐ Chinese ☐ Arabic ☐ Korean ☐ Russian ☐ Italian ☐ French
☐ French Creole ☐ Yiddish ☐ Polish ☐ Tagalog ☐ Benga ☐ Albanian ☐ Greek ☐ Urdu

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact VillageCareMAX at 1-855-296-8800 if you need information in an accessible format other than what's listed above. Our office hours are 8:00 am to 8:00 pm, 7 days a week. 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 center (VillageCareMAX will assign you a PCP if you do not choose one):

Name: _____
Address: _____

Telephone: _____
NPI: _____

Are you currently seeing this doctor? ☐Yes ☐No

I want to get the following materials via email. Select one or more.

Pre-Enrollment

☐ Summary of Benefits
☐ Medicare Star Ratings Document

Enrollment

☐ Evidence of Coverage
☐ Provider and Pharmacy

Directory

☐ List of Medicaid Advantage Plus (MAP) Plans
☐ Formulary (List of Covered Drugs)
☐ Consumer Long Term Care Guide
☐ Completed Medicare Enrollment Form

E-mail address: _____
_____

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 "Electronic Funds Transfer (EFT)", "credit card" 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.**]

Please select a premium payment option:

- ☐ Get a bill. You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month.
- ☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:
  - Bank Name: _____
  - Account holder name: _____
  - Bank routing number: _ _ _ _ _ _ _ _ _ Bank account number: _ _ _ _ _ _ _ _ _ _ _ _ _
  - Account type: Checking Saving
- ☐ Credit Card. Please provide the following information:
  - Type of Card: _____
  - Name of Account holder as it appears on card: _____
  - Account number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
  - Expiration Date: _ _/_ _ _ _ (MM/YYYY)
  - CVV: _____
  - Billing Address: _____
  - City: _____
  - State: _____
  - ZIP Code: _____
- ☐ **Automatic deduction from your monthly Social Security benefits**
- ☐ **Automatic deduction from your monthly Railroad Retirement Board benefits (RRB)**

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 VillageCareMAX the Part D-IRMAA.

For individuals helping enrollee with completing this form only

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): _____

Office Use Only:

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

Staff member/agent/broker application receive date: _____

Contract H2168/Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ MA OEP: _____ SEP (type): _____OEPI: _____

Not Eligible: _____

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.