Individual Enrollment Request Form

Please contact PHP (HMO SNP) if you need information in another language or format (Braille).

To enroll in PHP, please provide the following information:

LAST Name:	FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date: (__ __/__ __/__ __ __ __) (M M/D D/Y Y Y Y)	Sex: ☐ M ☐ F	Home Phone Number: ( ) –	Alternate Phone Number: ( ) –

Permanent Residence Street Address *(P.O. Box is not allowed)*:

City:	County:	State:	ZIP Code:

Mailing Address *(only if different from your Permanent Residence Address)*:

Street Address: City: State: ZIP Code:

Emergency Contact: _____

Phone Number: _____ **Relationship to You**: _____

E-mail Address:

Please provide your Medicare insurance 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 your letter from the Social Security Administration or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

Is Entitled To: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Paying a late enrollment penalty, if applicable:

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or credit card each month or quarterly. You can also choose to pay your late enrollment penalty by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed 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 the RRB. DO NOT pay PHP the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you don't select a payment option, you will get a bill each month.

Enrollee Name: _____

Please select a late enrollment penalty payment option, if applicable:

☐ Get a bill.

☐ 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)

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all late enrollment penalties due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly late enrollment penalty.)

Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, State pharmaceutical assistance programs or AIDS drug assistance programs (ADAP).

Will you have other prescription drug coverage in addition to PHP?

☐ Yes ☐ No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	ID # for this coverage:	Group # for this coverage:

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If "yes," please provide the following information:

Name of Institution: _____ Phone Number: _____

Address (number and street): _____

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

If yes, please provide your Medicaid number: _____

5. Do you or your spouse work? ☐ Yes ☐ No

6. Clinical Qualifying Questions:
   a) Have you been diagnosed as HIV-positive? ☐ Yes ☐ No
      If yes, what was the date of diagnosis (month and year)? _____
   b) Have you been diagnosed with AIDS? ☐ Yes ☐ No
      If yes, what was the date of diagnosis (month and year)? _____

7. Medication Questions:
   a) Are you now or have you ever taken medication for HIV/AIDS? ☐ Yes ☐ No
   b) What were/are the medications?

_____

_____

_____

_____

Enrollee Name: _____

Please choose the name of a Primary Care Physician (PCP), clinic or health center:

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in accessible format:

- ☐ **Spanish**
- ☐ **Large Print**

If you need information in accessible format or language other than what is listed above, please call PHP. Our office hours are 8:00 a.m. to 8:00 p.m., seven days a week.

California Enrollees: Please call Member Services at (800) 263-0067. TTY users should call 711.
Florida Enrollees: Please call Member Services at (888) 456-4715. TTY users should call 711.
Georgia Enrollees: Please call Member Services at (833) 267-6768. TTY users should call 711.

PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining PHP could affect your employer or union health benefits. You could lose your employer or union health coverage if you join PHP. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read and sign on the next page:

By completing this enrollment application, I agree to the following:

PHP is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

PHP serves a specific service area. If I move out of the area that PHP serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of PHP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from PHP when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date PHP coverage begins, I must get all of my health care from PHP, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by PHP and other services contained in my PHP Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR PHP WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with PHP, he/she may be paid based on my enrollment in PHP.

Enrollee Name: _____

Release of Information:

By joining this Medicare health plan, I acknowledge that PHP will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that PHP will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposes, which follow all applicable Federal statutes and regulations. 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 authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (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 from Medicare.

Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:

Name : _____

Address: _____

Phone Number: (_____) _____-_____

Relationship to Enrollee: _____

Office Use Only:
Name of staff member/agent/broker (if assisted in enrollment): _____
Plan ID #: _____
Effective Date of Coverage: _____
ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____
Date application received by Member Services: _____

Enrollee Name: _____

Attestation of Eligibility for an 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.

☐ 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 *(insert date)* _____.

☐ I recently was released from incarceration. I was released on *(insert date)* _____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on *(insert date)* _____.

☐ I recently obtained lawful presence status in the United States. I got this status on *(insert date)* _____.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on *(insert date)* _____.

☐ 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 *(insert date)* _____.

☐ 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 *(insert date)* _____.

☐ I recently left a PACE program on *(insert date)* _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on *(insert date)* _____.

☐ I am leaving employer or union coverage on *(insert date)* _____.

☐ 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.

Enrollee Name: _____

☐ 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 *(insert date)* _____.

☐ 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 *(insert date)* _____.

☐ 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.

If none of these statements applies to you or you're not sure, please contact PHP to see if you are eligible to enroll. We are open 8:00 a.m. to 8:00 p.m., seven days a week.

California Enrollees: Call Member Services at (800) 263-0067 (TTY users should call 711).

Florida Enrollees: Call Member Services at (888) 456-4715 (TTY users should call 711).

Georgia Enrollees: Call Member Services at (833) 267-6768 (TTY users should call 711).

Discrimination Is Against the Law

PHP (HMO SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PHP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Member Services.

If you believe that PHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Member Services, P.O. Box 46160, Los Angeles, CA 90046, (800) 263-0067, TTY 711, Fax (888) 235-8552, email php@positivehealthcare.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-263-0067 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-263-0067（TTY：711）

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-263-0067 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-263-0067 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-263-0067 (TTY: 711) 번으로 전화해 주십시오.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-263-0067 (TTY (հեռատիպ)՝ 711):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما

فراهم می باشد. با 1-800-263-0067 (TTY: 711) تماس بگیرید.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-263-0067 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-263-0067（TTY: 711）まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-263-0067 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-263-0067 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-263-0067 (TTY: 711)។

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-263-0067 (TTY: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-263-0067 (TTY: 711) पर कॉल करें।

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-263-0067 (TTY: 711).