



Individual Enrollment Request Form

Who can use this form?

People with Medicare who want to join PHP (HMO SNP), a Medicare Advantage Special Needs Plan.

To join PHP, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area
- Have a prior HIV diagnosis in your medical record

Important: To join PHP, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join PHP:

- 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 PHP during fall open enrollment (October 15–December 7), we must get your completed form by December 7.
- If applicable, we will send you a bill for your late enrollment penalty. You can choose to sign up to have your late enrollment penalty payments deducted from your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

PHP
PO Box 46160
Los Angeles, CA 90046

Once we process your request to join, we will contact you.

How do I get help with this form?

Call PHP at:

California: (800) 263-0067

Florida: (888) 456-4715

Georgia: (833) 267-6768.

TTY users should 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 PHP al número debajo o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

California: (800) 263-0067, TTY 711

Florida: (888) 456-4715, TTY 711

Georgia: (833) 267-6768, TTY 711

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-NEW. 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.



Individual Enrollment Request Form

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

Select the plan you want to join:

PHP (HMO SNP) – \$0 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 P.O. Box):

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

Mailing address, if different from your permanent address (P.O. 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 PHP? Yes No

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

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)? _____

Medication Questions:

a) Are you now or have you ever taken medication for HIV/AIDS? Yes No
b) What were/are the medications?

IMPORTANT – Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in PHP.
- By joining this Medicare Advantage Plan, I acknowledge that PHP 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.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my PHP coverage begins, I must get all of my medical and prescription drug benefits from PHP. Benefits and services provided by PHP and contained in my PHP "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor PHP will pay for benefits or services that are not covered.
- 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:

Enrollee Name: _____

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.
Select one if you want us to send you information in a language other than English. <input type="checkbox"/> Spanish
Select one if you want us to send you information in an accessible format. <input type="checkbox"/> Large print <input type="checkbox"/> Audio CD Please contact PHP 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, seven days a week. <i>California Enrollees:</i> Please call Member Services at (800) 263-0067. TTY users should call 711. <i>Florida Enrollees:</i> Please call Member Services at (888) 456-4715. TTY users should call 711. <i>Georgia Enrollees:</i> Please call Member Services at (833) 267-6768. TTY users should 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: _____
I want to get the following materials via email. Select one or more. <input type="checkbox"/> New enrollee packet that includes Confirmation of Enrollment letter, Evidence of Coverage, Provider and Pharmacy Directories, etc. <input type="checkbox"/> Annual mailing documents that includes the Annual Notice of Changes for next year and next year's Evidence of Coverage, List of Covered Drugs (Formulary) and Provider and Pharmacy Directories <input type="checkbox"/> Plan newsletters and wellness program announcements E-mail address: _____
Paying a late enrollment penalty, if applicable
You can pay any late enrollment penalty that you currently have or may owe by mail or credit card each month. You can also choose to pay your late enrollment penalty by having it automatically taken out of your Social Security or Rail Road Retirement Board (RRB) benefit each month. 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 late enrollment penalty. The amount is usually take out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay PHP the Part D-IRMAA.
Please select a late enrollment penalty payment option, if applicable: <input type="checkbox"/> Get a bill. <input type="checkbox"/> 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) <input type="checkbox"/> Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from: <input type="checkbox"/> Social Security <input type="checkbox"/> RRB
Are you a resident in a long-term care facility, such as a nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," please provide the following information: Name of Institution: _____ Phone Number: _____ Address (number and street): _____
Are you enrolled in your State Medicaid program? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide your Medicaid number: _____

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: _____

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.