OMB No. 0938-1378
Expires: 7/31/2023

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 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.

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

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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.
☐ Spanish

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

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.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic or health center:

I want to get the following materials via email. Select one or more.
☐ New enrollee packet that includes Confirmation of Enrollment letter, Evidence of Coverage, Provider and Pharmacy Directories, etc.
☐ 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
☐ 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:
☐ 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

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): _____

Are you enrolled in your State Medicaid program? ☐ Yes ☐ 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: _____
Application Date: _____

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.

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).