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

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 (800) 263-0067. 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 PHP al (800) 263-0067, 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.

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.

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:	Middle Initial:

Birth Date: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Sex: ☐ Male ☐ Female	Phone Number: ( ) –

Permanent Residence Street Address *(Don't enter a P.O. Box)*:

City:	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.
- 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 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.
- 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:

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.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Black or African American

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to Answer**

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 at (800) 263-0067 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. 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 taken 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

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) 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 (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.
- ☐ 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 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 PHP at (800) 263-0067 (TTY users should call 711) to see if you are eligible to enroll. Our office hours are 8:00 am to 8:00 pm, seven days a week.