



## Individual Enrollment Request Form

### Reminders:

### 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.

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 0938-1378. 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.

- 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 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.



Individual Enrollment Request Form

Section 1 – All fields on this page are required (unless marked optional)			
Select the plan you want to join: <input type="checkbox"/> PHP (HMO SNP) – \$0 per month			
FIRST Name:		LAST Name:	
Middle Initial:			
Birth Date: (MM/DD/YYYY) (    /    /    )		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Phone Number: (    )    –			
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:		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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, what was the date of diagnosis (month and year)?			
b) Have you been diagnosed with AIDS? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
b) What were/are the medications?			
IMPORTANT – Read and sign below:			
<ul style="list-style-type: none"><li>• I must keep both Hospital (Part A) and Medical (Part B) to stay in PHP.</li><li>• 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.</li><li>• 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).</li><li>• 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.</li><li>• 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.</li><li>• 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:<ul style="list-style-type: none"><li>1) This person is authorized under State law to complete this enrollment, and</li><li>2) Documentation of this authority is available upon request by Medicare</li></ul></li></ul>			
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 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      ☐ Russian

Select one if you want us to send you information in an accessible format.  
☐ Braille                      ☐ Large Print                      ☐ Audio CD                      ☐ Data 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

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: \_\_\_\_\_  
  
National Producer Number (Agents/Brokers only): \_\_\_\_\_  
  
Signature: \_\_\_\_\_

**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 and 1860D-1 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.