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

group health Cooperative of eau claire™

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C) AND MEDICARE PRESCRIPTION DRUG PLAN (PART D)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

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

When do I use this form?

You can join a plan:

- 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 a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
Cooperative Advantage (HMO D-SNP)
2503 N. Hillcrest Parkway
Altoona, WI 54720
Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Cooperative Advantage (HMO D-SNP) at 1-800-460-4641. 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 Cooperative Advantage (HMO D-SNP) al 1-800-460-4641. TTY users can call 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.

FOR STAFF/AGENT/BROKER USE ONLY	
Applicant Name:	
Medicaid/Forward Health ID Number:	
Proposed Coverage Start Date:	
Medicare A Effective Date:	Medicare B Effective Date:
Election Code Used (check the appropriate election code): ☐ ICEP ☐ IEP ☐ AEP ☐ OEP ☐ OEP New ☐ OEPI ☐ SEP If SEP, please list SEP here:	
Agent Name	Agent Number

FOR OFFICE USE ONLY	
Date Scanned into Advantasure:	Entered By:
Legacy ID:	

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

Select the plan you want to join: ☐ Cooperative Advantage (HMO D-SNP) $0 per month

FIRST name:	LAST name:	
Birth date: (MM/DD/YYYY)	Sex: ☐ Male ☐ Female	Phone number: ( )
Permanent residence street address (Don't enter a PO Box):		
City:	State:	ZIP Code:
Mailing address, if different from your permanent address (PO Box allowed):		
Street address:	City:	State: ZIP Code:

Your Medicare Information

Medicare Number	_ _ _ _ -_ _ _ -_ _ _ _

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Cooperative Advantage (HMO D-SNP)? ☐ Yes ☐ No

Name of other coverage: _____

Member number for this coverage: _____

Group number for this coverage: _____

IMPORTANT: Read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Cooperative Advantage (HMO D-SNP).
- By joining this Medicare Advantage, I acknowledge that Cooperative Advantage (HMO D-SNP) 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 Cooperative Advantage (HMO D-SNP) coverage begins, I must get all of my medical and prescription drug benefits from Cooperative Advantage (HMO D-SNP). Benefits and services provided by Cooperative Advantage (HMO D-SNP) and contained in my Cooperative Advantage (HMO D-SNP) "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Cooperative Advantage (HMO D-SNP) 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:

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 an accessible format

☐ Braille ☐ Large print ☐ Audio CD

Please contact Cooperative Advantage (HMO D-SNP) at 1-800-460-4641 if you need information in an accessible format other than what's listed above. Our office hours are Monday through Friday, 8 AM to 8 PM from April 1 - September 30th, and 8 AM to 8 PM seven days a week from October 1 – March 31. TTY users can 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.

☐ Member Communications/Documents E-mail address: _____

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.