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

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:

- Are a U.S. citizen or lawfully present in the United States.
- Reside in the service area of Cooperative Advantage.

Important: To join a Medicare Advantage Plan, you must be:

- Entitled to Medicare Part A.
- Enrolled in Medicare Part B.
- Eligible and enrolled in Wisconsin Medicaid.

WHEN DO I USE THIS FORM?

You can join a plan:

- Between October 15–December 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 – Enrollment
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 at 1-888-203-7770. TTY users can call 1-800-947-3529.

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 Dual al 1-888-203-7770 (TTY 1-800-947-3529) 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.

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

Select the plan you want to join:

☐ H7598-003 (Cooperative Advantage D-SNP) $0 - $43.10 per month

FIRST name:	LAST name:	Middle Initial (Optional):
Birth date: (MM/DD/YYYY)	Sex: ☐ Male ☐ Female	Phone Number:
Permanent Residence street address (Do not enter a PO Box):		
City:	County (Optional):	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: _ _ _ _ - _ _ _ - _ _ _ _

Answer these important questions

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

Name of other coverage:	Member number for this coverage:	Group number for this coverage
PCN Number for this coverage	BIN 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.
- By joining this Medicare Advantage Plan, I acknowledge that Cooperative Advantage 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).
- 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).
- 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.

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Continued...

- I understand that when my Cooperative Advantage coverage begins, I must get all of my medical and prescription drug benefits from Cooperative Advantage. Benefits and services provided by Cooperative Advantage and contained in my Cooperative Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Cooperative Advantage 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:
  i. This person is authorized under State law to complete this enrollment, and
  ii.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:

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Cooperative ADVANTAGE

Enrollment Request Form to Enroll in a Medicare Advantage Plan (Part C) and Medicare Prescription Drug Plan (Part D)

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
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ 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 at 1-888-203-7770 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 1-800-947-3529.

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

PAYING YOUR PLAN PREMIUMS

You can pay your monthly plan premium by mail, Electronic Funds Transfter (EFT), credit card each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad 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 plan premium. DON'T pay Cooperative Advantage (HMO D-SNP) the Part D-IRMMA.

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Section 2 *(continued)* – All fields on this page are optional

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Get a bill each month ☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name:	Account type: ☐ Checking ☐ Savings
Bank routing number:	Bank account number:

☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

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.