

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:

Attn: Sales Department
Chinese Community Health Plan
445 Grant Avenue
San Francisco, CA 94108

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Chinese Community Health Plan at 1-888-681-3888. TTY users can call 1-877-681-8898.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Chinese Community Health Plan al 1-888-681-3888 (TTY: 1-877-681-8898) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

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-NEW. 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.



MEDICARE ADVANTAGE INDIVIDUAL ENROLLMENT REQUEST FORM

SECTION 1 – All Fields on this Page are Required (unless marked optional)

Select the plan you want to join:

- CCHP Senior Program (HMO): \$42 per month
CCHP Senior Value Program (HMO): \$0 per month
CCHP Senior Select Program (HMO D-SNP): \$33.20* per month

*Note: To enroll in CCHP Senior Select Program (HMO D-SNP), you must receive Medi-Cal benefits. Monthly premium depends on your level of Low-Income Subsidy.

FIRST Name: LAST Name: Middle Initial:

Date of Birth (MM/DD/YYYY): Sex: Home Phone Number:
Male Female

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: - - - - - - - - - -

Answer these Important Questions:

- 1) Will you have other prescription drug coverage (like VA, TRICARE) in addition to CCHP Medicare coverage?
Name of other coverage:
Member # for this coverage:
Group # for this coverage:
2) Are you enrolled in your State Medicaid Program?
If yes, please provide your Medicaid number:
3) Are you a resident in a long-term care facility, such as a nursing home?
If yes, please provide the following information:
Name of Institution:
Address and Phone number of Institution (Number and Street):

IMPORTANT: Read and Sign Below:

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

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.

- Chinese Spanish

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

- Braille Large print

Please contact CCHP at 1-888-775-7888 if you need information in an accessible format other than what's listed above. Our office hours are 8:00 a.m. to 8:00 p.m., seven days a week. TTY users can call 1-877-681-8898.

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.

- All Evidence of Coverage (EOC) Formulary
 Provider/Pharmacy Directory Annual Notice of Change (ANOC)

E-mail address:

Paying your Plan Premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, "Electronic Funds Transfer (EFT)" or "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. 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 CCHP the Part D-IRMAA.**

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible 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.

Office Use Only

Name of staff member/agent/broker (if assisted in enrollment): _____

Effective Date of Coverage: _____

Plan ID: 001 005 007

ICEP AEP MAOEP SEP (type): _____

Not Eligible: _____

RECEIVED DATE STAMP

Broker assisted enrollments:

Please fax completed application to CCHP: 1-888-551-2247

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.

Chinese Community Health Plan (CCHP) is a Medicare Advantage HMO Plan with a Medicare contract and a California Medicaid program contract for our HMO D-SNP Plan. Enrollment in CCHP depends on contract renewals. Chinese Community Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.