CCHP Health Plan

445 Grant Avenue, San Francisco, CA 94108
Tel 1-415-955-8800 I Fax 1-415-955-8818
www.cchphealthplan.com

OMB No. 0938-1378
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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 January1)
- 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 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.

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. the plan. See "What happens next?" on this page to send your completed form to the plan.

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MEDICARE ADVANTAGE INDIVIDUAL ENROLLMENT REQUEST FORM

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

San Francisco and San Mateo Counties	Alameda County
Select the plan you want to join: ☐ **CCHP Senior Program (HMO): $38 per month** ☐ **CCHP Senior Value Program (HMO): $0 per month** ☐ **CCHP Senior Select Program (HMO D-SNP): $0* per month** **Note: To enroll in CCHP Senior Select Program (HMO D-SNP), you must receive Medi-Cal benefits.*	**Select the plan you want to join:** ☐ **CCHP Senior Value Program (HMO): $0 per month**

FIRST Name:	LAST Name:	(Optional) Middle Initial:

Birth Date (MM/DD/YYYY): (/ /)	Sex: ☐ Male ☐ Female	Phone Number (Required):	Email Address (required):

Permanent Residence Street Address (Don't enter a PO Box). For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:	(Optional) County:	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? ☐ Yes ☐ No

   Name of other coverage: _____

   Member # for this coverage: _____

   Group number for this coverage: _____

2) Are you enrolled in your State Medicaid Program? ☐ Yes ☐ No

   If yes, please provide your Medicaid number: _____

3) Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

   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.
- 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 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.
- 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 in this section 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, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer**
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban

What is your race? Select all that apply.

- ☐ American Indian or Alaska Native

Asian:

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

- ☐ Black or African American

Native Hawaiian or Other Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ White
- ☐ **I choose not to answer**

What is your ethnicity? Select all that apply.

- ☐ African American
- ☐ American
- ☐ Arab
- ☐ Asian Indian
- ☐ Black
- ☐ Chinese
- ☐ European
- ☐ Filipino
- ☐ Hispanic/Latino
- ☐ Iranian
- ☐ Korean
- ☐ Latin American
- ☐ Mexican
- ☐ Russian
- ☐ Vietnamese
- ☐ Other, please specify: _____
- ☐ Unknown
- ☐ **I choose not to answer**

What is your preferred language for health care?

WRITTEN	SPOKEN	WRITTEN	SPOKEN	WRITTEN	SPOKEN
	☐ American Sign Language (ASL)	☐	☐ Khmer	☐	☐ Tagalog
☐	☐ Arabic	☐	☐ Laotian	☐	☐ Vietnamese
☐	☐ Bulgarian	☐	☐ Persian	☐	☐ Other, please specify: _____
☐	☐ Chinese (Written) / Cantonese (Spoken)	☐	☐ Polish		
☐	☐ Chinese (Written / Mandarin (Spoken)	☐	☐ Punjabi	☐	☐ Unknown
☐	☐ English	☐	☐ Russian	☐	☐ **I choose not to answer**
☐	☐ Korean	☐	☐ Spanish		

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay or homosexual
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ I don't know
- ☐ **I choose not to answer**

Select one if you would prefer us to send you information in a language other than English or in an accessible format.

☐ Chinese ☐ Spanish ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

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:

Privacy Protection of Data

CCHP and Balance by CCHP are required to comply with various State and Federal laws to protect, secure, retain, and maintain confidentiality of your sensitive and personal information. These laws include, **but not limited to**, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Centers for Medicare and Medicaid Services (CMS), and the California Consumer Privacy Act (CCPA). CCHP has put in place policies and procedures to ensure that access to or use of your personal information is secure.

Policies and processes include standards on how CCHP manages access to and the utilization of identified race, ethnicity, preferred language, gender identity and sexual orientation information collected for current or prospective health plan members. CCHP discloses its procedures for managing access to and the use of collected race, ethnicity, preferred language, gender identity and sexual information at a minimum, at the time of data collection and on CCHP's website Compliance Privacy page at CCHPHealthPlan.com/yourconfidentialmedicalinfo. For questions on these policies, please call the CCHP Compliance Hotline at 415-955-8810 or email CCHPComplianceDept@cchphealthplan.com.

Paying your Plan Premiums

You can pay your monthly plan premium (if applicable), (including any late enrollment penalty you have or may owe) by mail, "Electronic Funds Transfer (EFT)" or by "credit card" each month. You can also choose to pay your premium (if applicable) 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 CCHP the Part D-IRMAA.

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: _____

Signature: _____ National Producer Number (Agents/Brokers only): _____

Office Use Only

Name of staff member/agent/broker

(if assisted in enrollment):_____ Plan ID: ☐001 ☐005 ☐007 ☐011

Effective Date of Coverage: _____

☐ ICEP ☐ AEP ☐ MAOEP ☐ SEP (type): _____

☐ Not Eligible: _____

Broker assisted enrollments:
Please fax completed application to CCHP: 1-415-955-8819

Note: _____

RECEIVED DATE STAMP

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.

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.