Mass Advantage Enrollment Form

MASS ADVANTAGE

OMB No. 0938-1378
Expires: 6/30/2026

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 (if applicable). 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: Mass Advantage, PO Box 219975, Kansas City, MO 64121-9975. Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Mass Advantage at (844) 513-0531 to enroll over the phone. 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 espanol: Lllame a Mass Advantage 844-513-0531. TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en espanol y un representante estara 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.

Section 1 – All fields in this section are required (unless marked optional)

Select the plan you want to join:

- ☐ Mass Advantage Basic (HMO) – $0 per month
- ☐ Mass Advantage Plus (HMO) – $95 per month
- ☐ Mass Advantage Premiere (PPO) – $0 per month
- ☐ Mass Advantage Extra (PPO) – $0 per month

Please enter your information as it appears on your Medicare card

First Name	Last Name	Middle Initial *(Optional)*

Birth Date *(mm/dd/yyyy)*	Sex	Phone Number	Alternate Phone Number *(Optional)*
__ __ /__ __ /__ __ __ __	☐ Male ☐ Female	( )	( )

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 *(Optional)*	State	Zip

Mailing address, if different from your permanent address *(PO Box allowed)*

City	County *(Optional)*	State	Zip

Your Medicare information

Medicare Number __ __ __ __ /__ __ __ /__ __ __ __

Part A Effective Date _____

Part B Effective Date _____

List your Primary Care Physician (PCP), Clinic, or Health Center:

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) 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 are assessed a Part D-Income Related Monthly Adjustment Amount,** you will be notified by the Social Security Administration. **You will be responsible for paying this extra amount in addition to your plan premium.** You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. **DO NOT pay the Part-D IRMAA to Mass Advantage.**

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 co-insurance. 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.ssa.gov/medicare/part-d-extra-help**.

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

☐ Electronic Funds Transfer (EFT) from your bank account each month.

Account Holder Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Account Type: ☐ Checking ☐ Savings

☐ Automatic deduction from your monthly Social Security or 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.)

Answer these important questions.

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

Name of other coverage

Member number for this coverage	Group number for this coverage

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 natural disaster.

If none of these statements applies to you or you're not sure, please contact Mass Advantage at (844) 513-0531 (TTY users 711) to see if you are eligible to enroll. Our office hours are Sunday through Saturday, 8:00 a.m. to 8:00 p.m. EST for October 1 through March 31 and Monday through Friday, 8:00 a.m. to 8:00 p.m EST for April 1 through September 30. TTY users can call 711.

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
- ☐ Yes, Mexican, Mexican-American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer**

What's your race? Select all that apply.

Asian:

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

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ White
- ☐ **I choose not to answer**

What is your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____
- ☐ **I choose not to answer**

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

- ☐ Lesbian or Gay
- ☐ 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 want us to send you information in a language other than English.

- ☐ Spanish

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Email Address	Mobile Phone Number

By listing my email address and mobile phone number I agree to receive communications via email and/or text messaging. Message & Data rates may apply.

Please contact Mass Advantage Basic (HMO) at (844) 918-0114, Mass Advantage Plus (HMO) at (844) 918-0114, Mass Advantage Premiere (PPO) at (844) 915-0234 or Mass Advantage Extra (PPO) at (844) 915-0234 if you need information in an accessible format other than what's listed. Our office hours are Sunday through Saturday, 8:00 a.m. to 8:00 p.m. EST for October 1 through March 31 and Monday through Friday, 8:00 a.m. to 8:00 p.m EST for April 1 through September 30. TTY users can call 711.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

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.

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 page 1 to send your completed form to the plan.

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

Agent Use Only	Agency *(if applicable)*

Agent Received Date	NPN

Agent First Name	Agent Last Name

Requested Plan Effective Date *mm/dd/yyyy (Optional)*	Agent Signature
__ __ /__ __ /__ __ __ __	

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Mass Advantage.
- By joining this Medicare Advantage Plan, I acknowledge that Mass 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 on page 7). 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 Medicare Advantage plan at a time - and that enrollment in this plan will automatically end my enrollment in another Medicare Advantage plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Mass Advantage coverage begins, I must get all of my medical and prescription drug benefits from Mass Advantage. Benefits and services provided by Mass Advantage and contained in my Mass Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Mass Advantage 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 below and fill out these fields:

Name	Address
Phone Number	**Relationship to Enrollee**