Mass Advantage Enrollment Form

MASS ADVANTAGE

OMB No. 0938-1378
Expires: 12/31/26

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 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.

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

My Information

First Name _____ Last Name _____ Middle Initial *(Optional)* _____

Date of Birth *(mm/dd/yyyy)* _____/_____/_____

Sex [ ] Male [ ] Female

Phone Number (___) _____

Alternate Phone Number *(Optional)* (___) _____

Permanent Residence Street Address *(Don't enter a PO Box)* _____

City _____ County *(Optional)* _____ State _____ Zip _____

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

City _____ County *(Optional)* _____ State _____ Zip _____

Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.

Your Medicare Information

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

Part A Effective Date _____ Part B Effective Date _____

Your Provider Information

List your Primary Care Physician (PCP), Clinic, or Health Center (*Optional*) _____

Are you currently a patient of this provider? (*Optional*) [ ] Yes [ ] No

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

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

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

Please contact Mass Advantage at (844) 918-0114 (HMO) or (844) 915-0234 (PPO). If you need information in an accessible format other than what is listed. Our office hours are Sunday through Saturday, 8:00 a.m. to 8:00 p.m. EST 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

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.

Email Address

Mobile Phone Number

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period (AEP) 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.

[ ] Annual Enrollment Period (AEP) — October 15 to December 7

[ ] I am new to Medicare. Initial Enrollment Period (IEP) — Starts 3 months before the month you turn 65 and ends 3 months after the month you turn 65.

[ ] Initial Coverage Election Period (ICEP) — 3 months before Medicare Part B coverage begins. Ends the month before Medicare coverage starts.

[ ] I am currently enrolled in a Medicare Advantage plan and want to switch Medicare Advantage plans or leave a Medicare Advantage plan during the Open Enrollment Period (OEP), January 1 to March 31.

Special Enrollment Periods (SEP)

[ ] 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 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.

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 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 Mass Advantage the Part D-IRMAA.

Please choose one payment option. If you don't select an option below, we'll send you a monthly bill.

[ ] 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.)

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.

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. agent, broker, SHIP counselor, family member, or other third party) 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 Medicare Part A (Hospital) and Medicare Part B (Medical) 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 6). 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 Private Fee-for-Service (PFFS) and MA Medical Savings Account (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