

# Mass Advantage Enrollment Form

## 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](https://www.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 830059, Birmingham, AL 35283. Once we 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 español:** Lllame a Mass Advantage 844-513-0531. TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español 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.

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

Select the plan you want to join:

- Mass Advantage Basic (HMO) - \$0 per month
- Mass Advantage Plus (HMO) - \$100 per month
- Mass Advantage Premiere (PPO) - \$0 per month

**Please enter your information as it appears on your Medicare card**

First Name	Last Name	Middle Initial <i>(Optional)</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Birth Date <i>(mm/dd/yyyy)</i>	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone Number	Alternate Phone Number <i>(Optional)</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Permanent Residence street address *(Don't enter a PO Box)*

City	County <i>(Optional)</i>	State	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

City	County <i>(Optional)</i>	State	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Your Medicare information**

Medicare Number

Part A Effective Date

Part B Effective Date

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

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## Paying Your Plan Premium

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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 automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check 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 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](http://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.

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### 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
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(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.)

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**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

<input type="text"/>	<input type="text"/>
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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.

## 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.

- |   |  |
|---|--|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin   | <input type="checkbox"/> Yes, Mexican, Mexican-American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican                                  | <input type="checkbox"/> Yes, Cuban                                |
| <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> <b>I choose not to answer</b>             |

What's your race? Select all that apply.

- |                                       |   |   |
|---------------------------------------|---|---|
| Asian:                                | Native Hawaiian and Pacific Islander:           | <input type="checkbox"/> American Indian or Alaska Native |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Guamanian or Chamorro  | <input type="checkbox"/> Black or African American        |
| <input type="checkbox"/> Chinese      | <input type="checkbox"/> Native Hawaiian        | <input type="checkbox"/> White                            |
| <input type="checkbox"/> Filipino     | <input type="checkbox"/> Samoan                 | <input type="checkbox"/> <b>I choose not to answer</b>    |
| <input type="checkbox"/> Japanese     | <input type="checkbox"/> Other Pacific Islander |   |
| <input type="checkbox"/> Korean       |   |   |
| <input type="checkbox"/> Vietnamese   |   |   |
| <input type="checkbox"/> Other Asian  |   |   |

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

Please contact Mass Advantage Basic (HMO) at 844-918-0114, Mass Advantage Plus (HMO) at 844-918-0114 or Mass Advantage Premiere (PPO) at 844-915-0234 if you need information in an accessible format other than what's listed above. 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

Email Address

Phone Number

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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.

## 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.

<b>Agent Use Only</b>	Agency <i>(if applicable)</i>
Agent Received Date	NPN
Agent First Name	Agent Last Name
Requested Plan Effective Date <i>mm/dd/yyyy (Optional)</i>	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).
- 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.
- 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 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.
- 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.

If you're the authorized representative, sign below and fill out these fields:

Signature	Today's Date
<input type="text"/>	<input type="text"/>
Name	Address
<input type="text"/>	<input type="text"/>
Phone Number	Relationship to Enrollee
<input type="text"/>	<input type="text"/>