OMB No. 0938-1378
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INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

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:

HealthTeam Advantage
300 East Wendover Ave, Suite 121
Greensboro, NC 27401

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

How Do I Get Help With This Form?

Call HealthTeam Advantage at **877-905-9216**. 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: Llame a HealthTeam Advantage al |**877-905-9216**/TTY 711 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.

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

Select the plan you want to join:

- ❑ **Plan I** (PPO) H9808-004 **$0 per m onth**
- ❑ **Plan II** (PPO) H9808-005 **$44 per month**
- ❑ **Eagle Plan** (PPO) H9808-009 **$0 per month**
- ❑ **Vitality Plan** (PPO) H9808-10 **$0 per month**
  - ❑ **Dental Rider $40 per month**
- ❑ **Diabetes & Heart Care** (HMO CSNP) H2624-001 **$0 per month**
- ❑ **Cardinal Plan** (HMO) H2624-004 **$0 per month**

FIRST Name:	LAST Name:	[Optional: Middle Initial]:
Birth Date: (MM/DD/YYYY) (_____/_____/_____)	Sex: ❑ Male ❑ Female	Phone Number: ( )

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:	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:

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

Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage: _____

If you are signing up for the HMO CSNP plan, please complete the **Chronic Condition Verification Form.**

IMPORTANT: Read and sign below:

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

Are you of 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.

- ❑ American Indian or Alaska Native

Asian:

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

- ❑ Black or African American

Native Hawaiian and Pacific Islander:

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

- ❑ 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

Please contact HealthTeam Advantage at 888-965-1965 (TTY 711) if you need information in an accessible format other than what's listed above. Our office hours are October 1-March 31, 8 a.m. to 8 p.m. ET, seven days a week, or April 1-September 30, 8 a.m. to 8 p.m. ET, Monday through Friday. TTY users can call 711.

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.

- ❑ Evidence of Coverage
- ❑ Provider Directory
- ❑ Comprehensive Formulary
- ❑ Member Newsletters/Alerts

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, 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.**

Please select a plan premium and/or late enrollment payment option:

❑ Get a bill each month.

❑ Electronic funds transfer (EFT) from your bank account each month.
Please enclose a VOIDED check or provide the following:

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.*

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 HealthTeam Advantage 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)

AGENTS/BROKERS ONLY:

Date Application Received by Agent: _____

Plan ID #: _____ Effective Date of Coverage _____

ICEP/IEP: _____ AEP: _____ OEP: _____ SEP (type): _____ Not Eligible: _____

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.