OMB No. 0938-1378
Expires: 7/31/2024

cca health RHODE ISLAND

ENROLLMENT FORM 2023

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:

CCA Health Rhode Island
3 Davol Square
Suite C-300
Providence, RI 02903

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

How do I get help with this form?

Call CCA Health at 855-430-9292 (TTY 711)
Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a CCA Health al 855-430-9292 (TTY 711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 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.

Enrollment Form 2023

Please contact CCA Health Rhode Island if you need information in another language or format.

Section 1 – To enroll, please provide the following information:

Note to Applicant: For information about service area and premiums of *CCA Medicare Advantage* plans available to you, please refer to the Summary of Benefits. **Please check which plan you want to enroll in:**

☐ **CCA Medicare Preferred (PPO) –** $0 per month ☐ **CCA Medicare Value (PPO) –** $29 per month

☐ **CCA Medicare Maximum (HMO D-SNP) –** $0 per month

LAST Name: FIRST Name: M.I.: ☐ Mr. ☐ Mrs. ☐ Ms

Birth Date: ______ /______ /_________ | Sex: ☐ M ☐ F | Home Phone Number: (   ) _____-________ | Cell Phone Number: (   ) _____-________

Email Address: | **Contact Preference:** ☐ Mail ☐ Email ☐ Text ☐ Phone

Permanent Residence Street Address (No PO Box):

City: State: ZIP Code:

Mailing Address (only if different from above)**:**

City: State: ZIP Code:

Emergency Contact: **Phone Number:** **Relationship to you:**

Your Medicare information

Medicare Number:____________________________ **Part A** ______ /______ /______ **Part B** ______ /______ /______

Will you have other prescription drug coverage in addition to this plan? ☐ Yes ☐ No

Name of other coverage: ______________ ID # for this coverage: ______________ Group # for this coverage: ______________

Are you enrolled in your State Medicaid program? ***(Required for enrollment in SNP Plans)**

☐ Yes ☐ No If "yes," please provide your Medicaid number:________________________________

IMPORTANT – Read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in CCA Medicare Advantage Plans.
- By joining this Medicare Advantage Plan, I acknowledge that CCA Health 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 3).
- 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).
- 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.

IMPORTANT – Read and sign below (continued)

- I understand that when my CCA Health coverage begins, I must get all of my medical and prescription drug benefits from CCA Health. Benefits and services provided by CCA Health and contained in my CCA Health "Evidence of Coverage" document (also know as a member contract or subscriber agreement) will be covered. Neither Medicare nor CCA Health will pay for benefits or services that are not covered.
- I understand that the phone numbers and/or email I provided on this application may be used by CCA Health or any of its contracted parties to contact me about my account, my health benefit plan or related programs, or services provided to me.
- 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.

Your Signature:

Proposed Effective Date: **Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:

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 Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **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

Please contact CCA Health at ***855-430-9292 if you need information in an accessible format other than what's listed above. Our office hours are 7 days a week, 8 am - 8 pm (April 1 - September 30: Monday through Friday, 8 am - 8 pm) TTY users can call 711.***

Please choose the name of a Primary Care Physician (PCP) from our Provider Directory:

Name: ____________________ **PCP #** ____________________ ☐ Current Patient

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 pay 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 RRB. DO NOT pay CCA Health the Part D-IRMAA.

Would you like the premium for this plan deducted from your SSA or RRB monthly benefit check?

☐ Yes ☐ No

I get monthly benefits from: ☐ Social Security ☐ RRB

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 enrolling during the Annual Enrollment Period (AEP) from October 15 to December 7.
- ☐ 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 ______ /______ /_________.
- ☐ I recently was released from incarceration. I was released on ______ /______ /_________.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ______ /______ /_________.
- ☐ I recently obtained lawful presence status in the United States. I got this status on ______ /______ /_________.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on ______ /______ /_________.
- ☐ 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 ______ /______ /_________.
- ☐ 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 ______ /______ /_________.
- ☐ I recently left a PACE program on ______ /______ /_________.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on ______ /______ /_________.
- ☐ I am leaving employer or union coverage on ______ /______ /_________.
- ☐ 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 ______ /______ /_________.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have the lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on ______ /______ /_________.
- ☐ I was affected by a major disaster or other emergency 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 disaster or other emergency.
- ☐ None of these statements apply to me.

If none of these statements apply to you or you're not sure, please contact CCA Health at **855-430-9292 (TTY users should call 711)** to see if you are eligible to enroll. We are open 7 days a week, 8 am–8 pm (From April 1–September 30: Monday through Friday, 8 am–8 pm)

Office use only

Staff Member/Agent/Broker Signature: ______________________________ **Agent/Broker ID#:** ☐☐☐☐

Date Accepted: _______________ Source Code: ______________________ Location: __________________________

Election Period: ICEP/IEP: _______________ AEP: _______________ SEP (type): _______________

Scope of Appointment (required if not seminar): ☐ Yes Seminar ☐ No Seminar

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.