MetroPlusHealth | **SHORT ENROLLMENT REQUEST FORM**

PLEASE NOTE: You should only use this form if you are changing from one MetroPlus Medicare Advantage plan to another. Do not use this form if you are enrolling in a MetroPlus Medicare Advantage plan for the first time or if you are a previous member of a MetroPlus Medicare Advantage plan but have disenrolled from the plan.

Name	Home Phone Number:
Medicare Number:	**NY State Medicaid CIN Number (if applicable):**
Permanent Street Address (P.O. Box is not allowed)	
City:	State: ZIP Code:

Mailing Address (only if different from your Permanent Street Address):
Street Address: City: State: ZIP Code:

Please fill out the following:

I am currently a member of the _____ plan in MetroPlus Health Plan with a monthly premium of $ _____.

I would like to change to the _____ plan in MetroPlus Health Plan.

I understand that this plan has different health benefits and a monthly premium of $_____.

Name of chosen Primary Care Physician (PCP), clinic or health center:	**Provider's ID #:**

Please check one of the boxes below if you would prefer us to send your significant documents in a language other than English or in an accessible format:

❑ Spanish ❑ Chinese ❑ Braille ❑ Large print ❑ Audio CD

Contact MetroPlus Health Plan at 1-866-986-0356 if you need information in an accessible format or language other than what is listed above. Our office hours are: 24 hours a day, 7 days a week. TTY users should call 711.

Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month. If you are assessed a Part D-Income Related MonthlyAdjustment 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 Railroad Retirement Board. Do NOT pay MetroPlus Health Plan the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, 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 won't have a coverage gap or a late enrollment penalty. Many people qualify 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.socialsecurity.gov/prescriptionhelp.

Your Plan Premium (Continued)

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. 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
- ❑ 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 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.)

Please Read and Sign Below:

MetroPlus Health Plan is a plan that has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with MetroPlus Health Plan, he/she may be paid based on my enrollment in MetroPlus Health Plan.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that MetroPlus Health Plan will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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 aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date MetroPlus Health Plan coverage begins, I must get all of my health care from MetroPlus Health Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by MetroPlus Health Plan and other services contained in my MetroPlus Health Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **WITHOUT AUTHORIZATION, NEITHER MEDICARE NOR METROPLUS HEALTH PLAN WILL PAY FOR THE SERVICES.**

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (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 from Medicare.

Signature:	**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: _____

OFFICE USE ONLY

Name of Staff Member / Agent / Broker (if assisted in enrollment):

_____ Date Received: _____

Plan ID #:_____ Effective Date of Coverage: _____

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

Marketing: Rep Code: _____ Site ID Code: _____

Event Name: _____

Attestation Of Eligibility For An Enrollment Period

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) _____.

Attestation Of Eligibility For An Enrollment Period (Continued)

- ❑ 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 disaster.

If none of these statements applies to you or you're not sure, please contact MetroPlus Health Plan at 1-866-986-0356 (TTY users should call 711) to see if you are eligible to enroll. We are open 24 hours a day, 7 days a week.

MetroPlus Health Plan is a HMO, HMO SNP plan with a Medicare contract. MetroPlus Health Plan has a contract with New York State Medicaid for MetroPlus UltraCare (HMO-DSNP) and a Coordination of Benefits Agreement with the New York State Department of Health for the MetroPlus Advantage Plan (HMO-DNSP). Enrollment in MetroPlus Health Plan depends on contract renewal. MetroPlus Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-986-0356 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-986-0356 (TTY: 711)。