✓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 of Plan you Are Enrolling in:		
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 #:**

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.

Are you 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
- ☐ Chinese
- ☐ Japanese
- ☐ Other Asian
- ☐ Vietnamese
- ☐ Asian Indian
- ☐ Filipino
- ☐ Korean
- ☐ Other Pacific Islander
- ☐ White
- ☐ Black or African American
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ **I choose not to answer.**

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.

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

Please Read and Sign Below (Continued)

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: _____

MetroPlus Health Plan, Inc. is a HMO, HMO SNP plan with a Medicare contract. MetroPlus Health Plan, Inc. 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, Inc. depends on contract renewal. MetroPlus Health Plan, Inc. 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)。

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: _____