CENTRAL HEALTH MEDICARE PLAN

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-866-314-2427, TTY:711 from 8 AM to 8 PM PT, 7 days a week.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.centralhealthplan.com or call 1-866-314-2427, TTY 711 to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month. If you are enrolling in Central Health Focus Plan (HMO) or Central Health Savings Plan (HMO) you will be eligible for a reduced Part B premium amount.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024. Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ Only applicable if enrolling onto Central Health Focus Plan (HMO C-SNP): This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a specific qualifying, severe or disabling chronic condition.
- ☐ Only applicable if enrolling onto Central Health Ventura Medi-Medi Plan (HMO D-SNP): This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.
- ☐ Effect on current coverage. Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.

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CENTRAL HEALTH MEDICARE PLAN

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

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:
Central Health Medicare Plan
PO Box 14248
Orange, CA 92863
Attention: Enrollment Department

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

How do I get help with this form?

Call Central Health Medicare Plan at 1-866-314-2427. 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 Central Health Medicare Plan al 1-866-314-2427, 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.

CENTRAL HEALTH MEDICARE PLAN

Enrollment Application

PO Box 14248
Orange, CA 92863

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

Select the plan you want to join:

☐ **Central Health Medicare Plan (HMO) 001** (LA/SB/RS/OC) $0 per month
☐ **Central Health Focus Plan (HMO C-SNP) 006** (FR/SC/AL/CC/SJ/LA/SB/OC) $0 per month
☐ **Central Health Savings Plan (HMO) 019** (LA/SB/RS/OC) $0 per month
☐ **Central Health Premier Plan I (HMO) 020-1** (LA/SC/SJ/FR/AL/CC) $0 per month
☐ **Central Health Premier Plan I (HMO) 020-2** (SB/RS/OC) $41 per month
☐ **Central Health Premier Plan II (HMO) 021-1** (SB/RS/OC) $0 per month
☐ **Central Health Premier Plan II (HMO) 021-2** (LA/SC/SJ/FR/AL/CC) $41 per month
☐ **Central Health Ventura Medicare Plan (HMO) 008** (VC) $0 per month
☐ **Central Health Ventura Medi-Medi Plan (HMO D-SNP) 009** (VC) $41 per month
☐ **Central Health San Mateo Medicare Plan (HMO) 018** (SM) $0 month

Last Name: First Name: Middle Initial:

Birth Date: (MM DD YYYY)	Sex:	Home Phone Number:	Cell Phone Number:
__ __ /__ __ /__ __ __ __	☐ Male ☐ Female	(__ __ __) __ __ __ - __ __ __ __	(__ __ __) __ __ __ - __ __ __ __

Permanent Residence Street Address (Don't enter a PO Box):

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 Central Health Medicare Plan? ☐ Yes ☐ No

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

Are you enrolled in your State Medicaid program?
If "yes", please provide the following information: ☐ Yes ☐ No

Medicaid ID Number: ______________ Medicaid DOB: ______________

Do you have Cardiovascular Disorder, Congestive Heart Failure and or Diabetes? ☐ Yes ☐ No

Applicant Name: ______________________________

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

IMPORTANT: Read and Sign below:

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

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.**

Applicant Name: ______________________________

Section 2 – All fields are optional

What is your preferred spoken language? ______________________________

Select one if you want us to send you information in a language other than English.

☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large Print ☐ Audio CD

Please contact Central Health Medicare Plan at 1-866-314-2427 if you need information in an accessible format other than what is listed above. Our office hours are 7 days a week, 8:00 AM – 8:00 PM (TTY: 711).

Do you work? ☐ Yes ☐ No	Does your spouse work? ☐ Yes ☐ No

Please choose the name of a Primary Care Physician (PCP) and Physician Group:

PCP Name:

Physician Group Name:	PCP ID#: ☐ Existing Patient

Please choose the name of a DeltaCare USA Provider:

Name of Dentist or Facility Name:

Facility ID:	City:

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail 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.**

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. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Central Health Medicare Plan the Part D-IRMAA.

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
- ☐ Social Security ☐ RRB

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.

Applicant 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) _______ /_______ /_______.

☐ 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) From_______ /_______ /_______ To _______ /_______ /_______.

☐ 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) _______ /_______ /_______.

Applicant Name: ______________________________

Attestation of Eligibility for an Enrollment Period (Cont.)

☐ 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.
Election period missed due to a FEMA related incident: ______________________________.

If none of these statements applies to you or you're not sure, please contact Central Health Medicare Plan at 1-866-314-2427 (TTY: 711) to see if you are eligible to enroll. We are open 7 days a week
8:00 AM - 8:00 PM.

Communication Preferences

Email Address (Optional): ______________________________

By providing us your email, you are giving consent for the plan to send personalized emails directly related to your health care or health plan.*

*You may opt-out at any time.

Opt-in for Electronic Materials: Send me my health plan materials in electronic format:

☐ Evidence of Coverage

☐ Provider Directory

☐ Formulary

☐ Other required materials

What is the cell phone number you wish to receive text messages on? (Optional)
(__ __ __) __ __ __- __ __ __ __

By providing us your cell phone number, you are giving consent for the plan to send personalized messages directly related to your health care or health plan. This may include benefit information and health and wellness information.*

*You may opt-out at any time. Message and data rates may apply to SMS.

Agent / Broker Information:

Please Read and Sign Below:

- I am licensed and certified by Central Health Medicare Plan to market and sell the plan
- I have provided a complete and accurate explanation to the beneficiary of the plan's eligibility requirements, benefits, and restrictions, with particular emphasis on the beneficiary's needs
- I have reviewed the application in its entirety to ensure that all fields are complete and accurate to my knowledge

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

FMO (if applicable): ______________________________

Agent / Broker Signature (if assisted in enrollment): ______________________________

CA Insurance License No: ____________ National Producer Number (NPN): ____________

Application Received Date: ______ /______ /______ **Proposed Effective Date:** ______ /______ /______

Please note: Completed applications must be faxed to Enrollment Department at 626-388-2371 within 24 hours of receipt by the broker.

Central Health Medicare Plan Office Use Only

Effective Date of Coverage: ______________________________

ICEP/IEP: ________ AEP: ________ OEP: ________ SEP: ________ LIS: ________ NOT ELIGIBLE: ________