OMB No. 0938-1378
Expires: 12/31/2026

ELITE HEALTH PLAN

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C) OR MEDICARE PRESCRIPTION DRUG PLAN (PART D)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug 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)

Important: To join a Medicare Prescription Drug Plan, you must also have either, or 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:
Elite Health Plan
P.O. Box 1489
Orange, CA 92856

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

How do I get help with this form?

Call Elite Health Plan at 800-958-1129. 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 Elite Health Plan al 800-958-1129 / 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:

☐ Elite Health Plan Signature HMO – $0 per month ☐ Elite Health Plan Core HMO – $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:	[Optional: 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 Elite Health Plan? ☐ Yes ☐ No

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

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Elite Health Plan.
- I must keep Hospital (Part A) or Medical (Part B) to stay in Elite Health Plan.
- By joining this Medicare Advantage Prescription Drug Plan, I acknowledge that Elite Health 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 or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Elite Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Elite Health Plan . Benefits and services provided by Elite Health Plan and contained in my Elite Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Elite Health 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 in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

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 Elite Health Plan at 1-800-958-1129 if you need information in an accessible format other than what's listed above. Our office hours are Monday – Friday 8:00 a.m. – 8:00 p.m. Pacific time. Between October 1st - March 31st, representatives are available seven days a week from 8 a.m. to 8 p.m. Pacific time, except for the major year-end holidays. 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: _____

Are you currently a patient of this Physician? ☐ Yes ☐ No

Medical group: _____

☐ I want to get the following materials via email. Select one or more.

☐ Annual materials (that are not required by mail) ☐ General Communications

E-mail address:

Paying your plan premiums

If we determine that you have you have a late enrollment penalty (or if you currently have a late enrollment penalty, you can pay by mail each month, quarterly or annually. **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. DON'T pay Elite Health Plan the Part D-IRMAA

If you don't select a payment option, you will get a bill each month. Please select a premium bill option:

☐ Check ☐ Auto deduction from: ☐ Social Security ☐ RRB

SSA / RRB may take two or more months to begin deduction.

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.

Relationship to enrollee: _____

National Producer Number (Agents/Brokers only): _____ Agent ID: _____

Name: _____

Signature: _____ Date: _____/_____/20_____

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.

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ELECTION PERIOD ATTESTATION

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.

Note – the codes are for internal use only (OEC/MARx).

- ☐ Annual Election Period. *[AEP-A]*
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period. *[OEP/MAOEP-M]*
- ☐ I am new to Medicare *[NEW/ETC-E(IEP)]*
- ☐ I'm new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started. *[RET/32]*
- ☐ I already have Hospital (Part A) and recently signed up for Medical (Part B). I want to join a Medicare Advantage Plan. *[IXW/WRX-I ICEP)]*
- ☐ I had Medicare prior to now, but I'm now turning 65. *[MRD/ETC-F (IEP2)]*
- ☐ 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). ____/____/_____. *[MOV/ETC-V]*
- ☐ I recently was released from incarceration. I was released on (insert date) ____/____/_____. *[MOV/ETC-V]*
- ☐ I recently returned to the United States after living permanently outside of the U S I returned to the U.S. on (insert date) ____/____/_____. *[MOV/ETC-V]*
- ☐ I recently obtained lawful presence status in the United States I got this status on (insert date) ____/____/_____. *[LAW/37]*
- ☐ I live in a long-term care facility, like a nursing home or a rehabilitation hospital. *[LT2/ETC-T]*
- ☐ I recently moved out of a long-term care facility, like a nursing home or a rehabilitation hospital. *[LT2/ETC-T]*
- ☐ I recently left a PACE program on (insert date) ____/____/_____. *[PAC/27]*
- ☐ I am leaving employer or union coverage on (insert date) ____/____/_____. *[LEC/ETC-W]*
- ☐ I lost other, non-Medicare drug coverage that's as good as Medicare drug coverage (creditable coverage), or my other, non-Medicare coverage changed and is no longer considered creditable. I lost my coverage on (insert date) ____/____/_____. *[LCC/22]*
- ☐ I lost my coverage because my plan no longer covers the area that I live. *[EOC/11]*

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☐ I lost my coverage because Medicare ended its contract with my plan. I got a letter from Medicare saying I could join another plan. *[MYT/11]*

☐ I'm in a State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program. *[PAP/38]*

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in my level of Medicaid, or lost Medicaid). *[MCD/ETC-U(LIS)]*

☐ I recently had a change in my Extra Help paying for my drug costs (newly got Extra Help, had a change in my level of Extra Help, or lost Extra Help) *[MCD/ETC-U(LIS)]*

☐ 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) _____/_____/_____. *[DIF/ETC-U]*

☐ 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) _____/_____/_____**.** *[SNP/35]*

☐ 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. *[DST/01]*

☐ I pay a premium for Part A and I signed up for Part B during the General Enrollment Period (January 1 - March 31 each year). I want to join a Medicare drug plan (Part D) or Medicare Advantage Plan with drug coverage.*[Pre/34]*

☐ I signed up for Part A (Hospital Insurance) or Part B (Medical Insurance) during a Special Enrollment Period I qualified for because of an exceptional circumstance. I want to join a Medicare Advantage Plan (with drug coverage).*[DSP/43]*

☐ None of these statements apply to me, however, I feel that I am eligible due to a special circumstance which would allow an exception to enroll (subject to approval). Please Explain:

_____

_____

If none of these statements applies to you, or you're not sure, please contact Elite Health Plan at 1-800-958-1129. TTY users should contact 711. We are open Monday – Friday 8:00 a.m. – 8:00 p.m. Pacific time. Between October 1st - March 31st, representatives are available seven days a week from 8 a.m. to 8 p.m. Pacific time, except for the major year-end holidays.

ATENCIÓN: Si usted habla español, los servicios gratuitos de asistencia lingüística están disponibles para usted También están disponibles de forma gratuita ayudas y servicios auxiliares apropiados para proporcionar información en formatos accesibles Llame al 1-800-958-1129 (TTY:711) o hable con su proveedor.