CDPHP® Medicare Choices
2018 HMO PLANS
ENROLLMENT APPLICATION
TO ENROLL IN CDPHP MEDICARE CHOICES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Please check which plan you want to enroll in:

- **CDPHP $0 Medicare Rx (HMO)** — $0.00 per month
- **CDPHP Basic Rx (HMO)** — $29.50 per month
- **CDPHP Value Rx (HMO)** — $57.00 per month
- **CDPHP Choice Rx (HMO)** — $122.00 per month
- **CDPHP Choice (HMO)** — $34.90 per month

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<th>LAST Name:</th>
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<td>FIRST Name:</td>
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**Permanent Residence Street Address (P.O. Box is not allowed):**

<table>
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<tr>
<th>City:</th>
<th>County:</th>
<th>State:</th>
<th>ZIP Code:</th>
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**Mailing Address (only if different from your Permanent Residence Address):**

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<tr>
<th>City:</th>
<th>State:</th>
<th>ZIP Code:</th>
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**Emergency Contact:**

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<th>Phone Number:</th>
<th>Relationship to You:</th>
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**PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION**

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.
- OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

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<tr>
<th>Name (as it appears on your Medicare card):</th>
<th>Medicare Number:</th>
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<th>Is Entitled To:</th>
<th>Effective Date:</th>
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**HOSPITAL (Part A)**

| _____ / _____ / _____ |

**MEDICAL (Part B)**

| _____ / _____ / _____ |

You must have Medicare Part A and Part B to join a Medicare Advantage plan.
PAYING YOUR PLAN PREMIUM

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay 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.

You can pay your monthly 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 are assessed 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 CDPHP Medicare Choices the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible 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 [http://www.socialsecurity.gov/prescriptionhelp](http://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. 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 each month
- [ ] Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIED check or provide the following:
  - Account Holder Name: ________________________________
  - Bank Routing Number: ____ ____ ____ ____ ____ ____ ____ ____
  - Bank Account Number: ______ ______ ______ ______ ______ ______ ______ ______
  - Account Type: [ ] Checking  [ ] Saving
- [ ] 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/RRB 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 ANSWER THESE IMPORTANT QUESTIONS

1. Do you have End-Stage Renal Disease (ESRD)?  □ Yes  □ No  If you have had a successful kidney transplant and/or you don’t need regular dialysis anymore, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don’t need dialysis. Otherwise, we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.

   Will you have other prescription drug coverage in addition to CDPHP Medicare Choices?  □ Yes  □ No

   If “yes,” please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage: __________________________

   ID # for this coverage: __________________________

   Group # for this coverage: __________________________

3. Are you a resident in a long-term care facility, such as a nursing home?  □ Yes  □ No

   If “yes,” please provide the following information:

   Name of Institution: __________________________

   Address & Phone Number of Institution (number and street):

   ________________________________________________

4. Are you enrolled in your state Medicaid program?  □ Yes  □ No

   If “yes,” please provide your Medicaid number: ________________________________________________

5. Do you or your spouse work?  □ Yes  □ No

Please choose the name of a Primary Care Physician (PCP), clinic, or health center:

If you would prefer that we send you information in Large Print, please check the box.  □ Large Print

Please contact CDPHP Medicare Choices at (518) 641-3950 or 1-888-248-6522 if you need information in a format or language other than what is listed above. Our hours are 8 a.m.–8 p.m. seven days a week, October 1–February 14. From February 15–September 30, Monday–Friday, our hours are 8 a.m.–8 p.m. A voice messaging service is used weekends, after-hours, and federal holidays. Calls will be returned within one business day. TTY users should call 711.
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 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 returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) ____________.
☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
☐ I get extra help paying for Medicare prescription drug coverage.
☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) ____________.
☐ 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 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) ____________.

☐ None of these statements applies to you or you’re not sure.

Please contact Capital District Physicians’ Health Plan, Inc. at (518) 641-3400 or 1-888-519-4455 (TTY users should call 711) to see if you are eligible to enroll. Our hours are 8 a.m.–8 p.m. seven days a week, October 1–February 14. From February 15–September 30, Monday–Friday, our hours are 8 a.m.–8 p.m. A voice messaging service is used weekends, after-hours, and federal holidays. Calls will be returned within one business day.

Release of information: By joining this Medicare health plan, I acknowledge that CDPHP Medicare Choices will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that CDPHP Medicare Choices 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 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): __________________________
Signature: ____________________________ Broker ID: __________________________
Plan ID#: ____________________________ Effective Date of Coverage: ____________
ICEP/IEP: _______ AEP: _______ SEP (type): _______ Not Eligible: _______
If you currently have health coverage from an employer or union, joining CDPHP Medicare Choices could affect your employer or union health benefits. You could lose your employer or union health coverage if you join CDPHP Medicare Choices. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn’t any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

By completing this enrollment application, I agree to the following:

CDPHP Medicare Choices is a Medicare Advantage plan and has a contract with the federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don’t have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare’s), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year, when an enrollment period is available (Example: October 15- December 7 of every year) or under certain special circumstances.

CDPHP Medicare Choices serves a specific service area. If I move out of the area that CDPHP Medicare Choices serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of CDPHP Medicare Choices, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from CDPHP Medicare Choices when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren’t usually covered under Medicare while out of the country, except for limited coverage near the U.S. border.

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

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with CDPHP Medicare Choices, he/she may be paid based on my enrollment in CDPHP Medicare Choices.
Discrimination is Against the Law

Capital District Physicians’ Health Plan, Inc. (CDPHP®) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CDPHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CDPHP:

► Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  » Qualified sign language interpreters
  » Written information in other formats (large print, audio, accessible electronic formats, other formats)

► Provides free language services to people whose primary language is not English, such as:
  » Qualified interpreters
  » Information written in other languages

If you need these services, contact the CDPHP Civil Rights Coordinator.

If you believe that CDPHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: CDPHP Civil Rights Coordinator, 500 Patroon Creek Blvd., Albany, NY 12206, 1-844-391-4803 (TTY/TDD: 711), Fax (518) 641-3401. You can file a grievance by mail, fax, or electronically at https://www.cdphp.com/customer-support/email-cdphp. If you need help filing a grievance, the CDPHP Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD 1-800-537-7697).

ATTENTION: If you speak a non-English language, language assistance services, free of charge, are available to you. Call 1-888-248-6522 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-248-6522 (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 1-888-248-6522（TTY: 711）

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-248-6522 (телетайп: 711)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-248-6522 (TTY: 711)


ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-248-6522 (TTY: 711)

шпор. اتهمفی وا مافقی رنها، زریا راف میت اونوا، شیدی مدر ری برو: ماکمرفیا 1-888-248-6522 (TTY: 711).

लक्षण करूनः यदि आपनी बांग्ला, कथा बनते पारेन, ताहले निंधूरचाय भाषा सहायता परिषेवा उपलब्ध आहे, फोन करून १-888-248-6522 (TTY: 711)।


ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 1-888-248-6522 (رمز هاتف الصم والبكم: 117)


ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-888-248-6522 (TTY: 711)

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-248-6522 (TTY: 711)