A plan for life.

CDPHP® Medicare Advantage

2022 HMO PLANS

# ENROLLMENT APPLICATION

Y0019_22_16707_C

21-16707

# Model Individual Enrollment Request Form to Enroll in a Medicare Advantage Plan (Part C)

OMB No. 0938-1378
Expires: 7/31/2023

## 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 January1)
- 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:

CDPHP
500 Patroon Creek Blvd
Albany, NY 12206
Attn: Medicare Enrollment

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

## How do I get help with this form?

Call CDPHP Medicare Sales at (518) 641-3400 or 1-888-519-4455. 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 CDPHP al 1-888-519-4455/711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

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# CDPHP Medicare Advantage HMO Plans 2022 Enrollment Application

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

**Select the plan you want to join:**

- ☐ CDPHP $0 Medicare Rx (HMO) — $0.00 per month
- ☐ CDPHP Basic Rx (HMO) — $31.00 per month
- ☐ CDPHP Value Rx (HMO) — $60.80 per month
- ☐ CDPHP Choice Rx (HMO) — $131.00 per month
- ☐ CDPHP Choice (HMO) — $39.90 per month

| **FIRST name:** | **LAST name:** | **[Optional: Middle Initial]:** |
|---|---|---|
| | | |

| **Birth Date: (MM/DD/YYYY)** | **Sex:** | **Home Phone Number:** | **Mobile Phone Number:** |
|---|---|---|---|
| __ __ / __ __ / __ __ __ __ | ☐ M ☐ F | (_____) _____-_____ | (_____) _____-_____ |

**Permanent Residence street address (Don't enter a PO Box):**

| **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 presciption drug coverage (like VA, TRICARE) in addition to CDPHP? ☐ Yes ☐ No

Name of other coverage: _____

Member number for this coverage: _____

Group number for this coverage: _____

## IMPORTANT: Read before signing

- I must keep both Hospital (Part A) and Medical (Part B) to stay in CDPHP.
- By joining this Medicare Advantage Plan, I acknowledge that CDPHP 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.
- 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 are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my CDPHP coverage begins, I must get all of my medical and prescription drug benefits from CDPHP. Benefits and services provided by CDPHP and contained in my CDPHP "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CDPHP will pay for benefits or services that are not covered.
- 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.

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**Section 2 – All fields on this page are optional**

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

Please contact CDPHP Medicare Advantage at (518) 641-3950 or 1-888-248-6522 if you need information in another language or format (Braille). Our office hours are 8 a.m.-8 p.m. seven days a week, October 1-March 31. From April 1-September 30, Monday-Friday, our hours are 8 a.m.-8 p.m. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day. 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:

E-mail address [Optional]:

**Paying your plan premiums**

You can pay your monthly premium (including any late enrollment penalty that you currently have or may owe) in one of three ways. Options are:

☐ Mail
☐ Electronic Funds Transfer — Please enclose a VOIDED check or provide the following:

Account Holder Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Account Type: ☐ Checking ☐ Saving

**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.**

☐ SS/RRB withdrawal

**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 CDPHP the Part D-IRMAA.

## 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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# 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 enrolling in a 5-star Medicare plan.
- ☐ 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) _____ .
- ☐ 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 a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of a natural disaster.
- ☐ **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–March 31. From April 1–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.

| **Signature** | **Today's date:** |
|---|---|
| If you're the authorized representative, sign above and fill out these fields: | |
| Name: | Address: |
| Phone Number: | Relationship to enrollee: |

| **Office Use Only:** | **DATE RECEIVED** |
|---|---|
| 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: _____ | |

# 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).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

**Multi-language Interpreter Services**

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)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-248-6522 (TTY: 711)번으로 전화해 주십시오.

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)

טפור .לאצפא וופ יירפ סעסיוורעס רלוה דארפש דייא ראפ ואהראפ וענעז ,שידיא טדער ריא ביוא :סאזקרעמפיוא 1-888-248-6522 (TTY: 711).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-888-248-6522 (TTY: 711)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-248-6522 (TTY: 711).

تنبيه: إذا كنت تتحدث لغة غير الإنجليزية، فإن خدمات المساعدة اللغوية المجانية متاحة لك. اتصل برقم 1-888-248-6522 (رقم هاتف الصم والبكم: 711)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-248-6522 (ATS : 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں.(TTY: 711) 1-888-248-6522

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-248-6522 (TTY: 711).

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)


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Capital District Physicians' Health Plan, Inc.
500 Patroon Creek Boulevard, Albany, NY 12206-1057

www.cdphp.com

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