



A plan for life.

CDPHP® Medicare Advantage
2024 HMO PLANS
PLAN CHANGE ELECTION FORM

2024 PPO Plans CDPHP® Medicare Advantage Plan Change Election Form

Name:		Member Number:		Home Phone Number: (____) _____ - _____	
Permanent Street Address (P.O. Box is not allowed):				Cell Phone Number: (____) _____ - _____	
City:		County:		State:	ZIP Code:
Mailing Address (Only if different from your Permanent Street Address): Street Address: City:				State:	ZIP Code:
I am currently a member of (check appropriate box): 2023 Plans			I wish to enroll in (check appropriate box): 2024 Plans		
<input type="checkbox"/> CDPHP \$0 Medicare Rx (\$0.00 per month)			<input type="checkbox"/> CDPHP \$0 Medicare Rx (\$0.00 per month)		
<input type="checkbox"/> CDPHP Basic Rx (\$31.00 per month)			<input type="checkbox"/> CDPHP Basic Rx (\$31.00 per month)		
<input type="checkbox"/> CDPHP Value Rx (\$58.30 per month)			<input type="checkbox"/> CDPHP Value Rx (\$53.80 per month)		
<input type="checkbox"/> CDPHP Choice Rx (\$128.50 per month)			<input type="checkbox"/> CDPHP Choice Rx (\$124.00 per month)		
<input type="checkbox"/> CDPHP Choice (\$39.90 per month)			<input type="checkbox"/> CDPHP Choice (\$39.90 per month)		
Name of chosen Primary Care Physical (PCP), clinic, or health center: _____					
The 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.					
<input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin		<input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a			
<input type="checkbox"/> Yes, Puerto Rican		<input type="checkbox"/> Yes, Cuban			
<input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin					
<input type="checkbox"/> I choose not to answer.					
What's your race? Select all that apply.					
<input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Black or African American			
Asian:		Native Hawaiian and Pacific Islander:			
<input type="checkbox"/> Asian Indian		<input type="checkbox"/> Guamanian or Chamorro			
<input type="checkbox"/> Chinese		<input type="checkbox"/> Native Hawaiian			
<input type="checkbox"/> Filipino		<input type="checkbox"/> Samoan			
<input type="checkbox"/> Japanese		<input type="checkbox"/> Other Pacific Islander			
<input type="checkbox"/> Korean		<input type="checkbox"/> White			
<input type="checkbox"/> Vietnamese		<input type="checkbox"/> I choose not to answer.			
<input type="checkbox"/> Other Asian					
Please contact CDPHP Medicare Advantage at (518) 641-3950 or 1-888-248-6522 if you need information in an accessible or alternate format. 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. TTY users should call 711.					
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 plan 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) 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 Advantage the Part D-IRMAA.					

YOUR PLAN PREMIUM *(continued)*

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 coinsurance. 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.ssa.gov/medicare/part-d-extra-help.

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.

Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or include the following:

Account Holder Name: _____ Account Type: Checking Saving

Bank Routing Number: _____

Bank Account Number: _____

Automatic deduction from your monthly Social Security or 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

CDPHP 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 CDPHP Medicare Advantage, he/she may be paid based on my enrollment in CDPHP Medicare Advantage.

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 CDPHP Medicare Advantage 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 CDPHP Medicare Advantage coverage begins, I must get all of my health care from CDPHP Medicare Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by CDPHP Medicare Advantage and other services contained in my CDPHP Medicare Advantage *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR CDPHP MEDICARE ADVANTAGE 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:
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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: _____

DATE RECEIVED



Discrimination is Against the Law

Capital District Physicians' Health Plan, Inc., CDPHP Universal Benefits, Inc., and Capital District Physicians' Healthcare Network, Inc. (collectively referred to as CDPHP®) comply with applicable federal civil rights laws and do 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 Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-248-6522 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-248-6522 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-888-248-6522 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-888-248-6522 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-248-6522 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-248-6522 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-888-248-6522 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-248-6522 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-248-6522 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-248-6522 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-888-248-6522 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-248-6522 (TTY: 711) पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-248-6522 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-248-6522 (TTY:711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-248-6522 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-248-6522 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-888-248-6522 (TTY: 711) にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。



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Capital District Physicians' Health Plan, Inc.
500 Patroon Creek Boulevard, Albany, NY 12206-10 57

www.cdphp.com

23-24152