A plan for life.

CDPHP® Medicare Advantage

GROUP HMO & PPO PLANS

MEMBER APPLICATION

Y0019_GR25_27145_C

24-27145

Group Enrollment Request Form to Enroll in a Medicare Advantage Plan (Part C)

Who can use this form?

People with Medicare who are eligible to join their employer based Medicare Advantage Plan.

To join a plan, you must:

- Reach out to your employer to confirm eligibility for this plan
- 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)

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.

Applicant:

Please print and use ink. If you have questions about benefits, pharmacy, or the CDPHP® provider network, call CDPHP member services at (518)641-3950 or 1-888-248-6522 (TTY:711).

Reminders:

- Your application must be completed and submitted to your employer prior to your requested effective date.
- Contact your employer for information about enrollment and to confirm premium amount and payment responsibilities.

What happens next?

- Send your completed and signed form to your employer prior to the requested effective date.
- Once your enrollment is processed, you will receive an ID card (with a new ID number)and a welcome packet in the mail.
- If you previously had a non-Medicare CDPHP plan, you will receive a letter telling you that we have ended your membership in that plan.This is a necessary step, but rest assured, you are covered by your new Group Medicare Advantage Plan.

Employer Group/Broker:

Complete the "Employer Group Office Use only" section at the beginning of the application. Scan and email to: MedicareEligibility@cdphp.com or fax to (518) 641-5006.

Member:

Return completed application to your employer.

Employer:

Complete Employer section and email to MedicareEligibility@cdphp.com or fax to (518)641-5006.

CDPHP Group Medicare Enrollment Application

FOR EMPLOYER GROUP OFFICE USE ONLY			
Employer Group Admin Initials *(required)*:	Effective Date:	QE or Reason:	☐ ICEP/IEP ☐ OEP ☐ AEP ☐ SEP
Employer or Union Name:		Group #:	

Please note: By submitting this application, you attest that the member below is not working and/or eligible to receive employer or union benefits. (Only applies to groups >20 employees.) If the applicant is currently enrolled in a CDPHP active offering through your group, please disenroll through your standard procedure (i.e. electronic enrollment file, secure portal, enrollment/change form).

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

Select the plan you want to join:

☐ HMO ☐ PPO

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

Birth Date: (MM/DD/YYYY) __ __ / __ __ / __ __ __ __

Sex: ☐ M ☐ F

Home Phone Number: (____) ____-_____

Mobile 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.)**:**

Street Address:

City: **[Optional: County]:** **State:** **ZIP Code:**

Mailing Address (only if different from your Permanent Residence Address)**:**

Street Address: City: State: ZIP Code:

E-mail (Optional)

Your Medicare information:

Medicare Number: ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Answer these important questions:

Will you have other prescription 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: _____

Are you the retiree? ☐ Yes ☐ No If "Yes", retirement date __ __ / __ __ / __ __ __ __

If "No" name of retiree ☐ Yes ☐ No If "Yes", name of spouse (if enrolling) _____

Please contact your group administrator for assistance with enrolling eligible family members. A separate application is needed for each person to be enrolled in this plan.

Member: Return completed application to your employer. **Employer:** Complete Employer section and email to MedicareEligibility@cdphp.com or fax to (518) 641-5006.

CDPHP Group Medicare Enrollment Application

Section 1 – All fields on this page are required (unless marked optional) ***(continued from previous page)***

IMPORTANT: Read carefully before signing

- CDPHP Medicare Advantage 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 only be in 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. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- 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 if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.
- CDPHP Medicare Advantage serves a specific service area. If I move out of the area that CDPHP Medicare Advantage 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 Advantage, 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 Advantage 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 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.
- 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.
- 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.
- If I am enrolled in a PPO plan, I understand that when my CDPHP coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services. If medically necessary, CDPHP provides refunds for all covered services, even if I get services out of network.
- 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.

Member: Return completed application to your employer. **Employer:** Complete Employer section and email to MedicareEligibility@cdphp.com or fax to (518) 641-5006.

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:

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

Native Hawaiian and Pacific Islander:
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

☐ Black or African American
☐ White
☐ **I choose not to answer.**

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:	
Name of staff member/agent/broker (if assisted in enrollment): _____ Signature: _____ Broker ID: _____	**DATE RECEIVED**
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.	
Name:	Relationship to enrollee:
Signature:	National Producer Number (Agents/Brokers only):

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.

Member: Return completed application to your employer. **Employer:** Complete Employer section and email to MedicareEligibility@cdphp.com or fax to (518) 641-5006.

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, 6 Wellness Way, Latham, NY 12110, 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.

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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 quí vị cần thông dịch viên xin gọi 1-888-248-6522 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí 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 답해 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ございます。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。

Important Information and Notes

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Capital District Physicians' Health Plan, Inc.
www.cdphp.com
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