A plan for life.

CDPHP® Medicare Advantage

GROUP HMO & PPO PLANS

MEMBER APPLICATION

Y0019_GR26_30231_C

25-30231

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:

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.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-888-248-6522 (TTY: 711) or speak to your provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-888-248-6522 (TTY: 711) o hable con su proveedor.

Traditional Chinese: 注意：如果您說[台語]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-888-248-6522（TTY：711）或與您的提供者討論。

Russian: ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-888-248-6522 (TTY: 711) или обратитесь к своему поставщику услуг.

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.

Korean: 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-888-248-6522(TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Italian: ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-888-248-6522 (TTY: 711) o parla con il tuo fornitore.

Yiddish: נאטיץ: אויב איר רעדט יידיש, שפראך הילף סערוויסעס זענען בארעכטיגט פאר דיר פריי. צונעמען אַידס און באַדינונגס פֿאַר פֿראַווייַדינג אינפֿאָרמאַציע אין צוטריטלעך פֿאָרמאַטירונגען זענען אויך בנימצא פריי. רופן 1-888-248-6522 (TTY: 711) אָדער רעדן מיט דיין טרעגער.

Bengali: মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহাতা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-888-248-6522 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

Polish: UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-888-248-6522 (TTY: 711) lub porozmawiaj ze swoim dostawcą.

Arabic: تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-888-248-6522 (TTY: 711) أو تحدث إلى مقدم الخدمة.

French: ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-888-248-6522 (TTY: 711) ou parlez à votre fournisseur.

Urdu: توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔1-888-248-6522 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-888-248-6522 (TTY: 711) o makipag-usap sa iyong provider.

Greek: ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-888-248-6522 (TTY: 711) ή απευθυνθείτε στον πάροχό σας».

Albanian: VINI RE: Nëse flisni [shqip], shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 1-888-248-6522 (TTY: 711) ose bisedoni me ofruesin tuaj të shërbimit.

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