

2027 CDPHP® Medicare Group Advantage (HMO) and (PPO) Employer/Union Group Health Plan Enrollment Request Form



CDPHP
Attn: Enrollment Operations
PO Box 31790
Rochester, NY 14603-1790

Please contact CDPHP if you need information in another language or format (Braille).



To Enroll in CDPHP Please Provide the Following Information:

EMPLOYER OR UNION NAME:

GROUP #:

SUBGROUP/CLASS/ENROLLMENT CODE:

EFFECTIVE DATE (MM/DD/YYYY):

Please check which plan you want to enroll in:

☐ CDPHP Group Medicare Advantage (HMO) ☐ CDPHP Group Medicare Advantage (PPO)

LAST NAME:

FIRST NAME:

MIDDLE INITIAL:

BIRTH DATE (MM/DD/YYYY):

SEX:

☐ MALE

☐ FEMALE

HOME PHONE NUMBER:

PERMANENT RESIDENCE STREET ADDRESS (DON'T ENTER A PO BOX):

CITY:

COUNTY:

STATE:

ZIP CODE:

MAILING ADDRESS, IF DIFFERENT FROM YOUR PERMANENT ADDRESS (PO BOX ALLOWED):

STREET ADDRESS:

CITY:

STATE:

ZIP CODE:

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.

CDPHP is an HMO plan and PPO plan with a Medicare contract. Enrollment in CDPHP depends on contract renewal.

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled to: Effective Date:

HOSPITAL (Part A)

MEDICAL (Part B)

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Please read and answer these important questions:

1 Are you the retiree? ☐ YES ☐ NO

If yes, retirement date (month/date/year):

If no, name of retiree:

2 Do you or your spouse work? ☐ YES ☐ NO

If yes, please provide name of employer:

3 Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to CDPHP? ☐ YES ☐ NO

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

Name of other coverage:

ID# for coverage:

4 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):

IMPORTANT: Please read the following

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

CDPHP 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.
- 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 serves a specific service area. If I move out of the area that CDPHP 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, 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 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.

IMPORTANT: Read and Sign on the Next Page:

IMPORTANT: Read and Sign Below:

- I understand that beginning on the date CDPHP coverage begins, I must get all of my health care from CDPHP, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by CDPHP and other services contained in my CDPHP Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR CDPHP 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, he/she may be paid based on my enrollment in CDPHP.
- **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 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're the authorized representative, sign above and fill out these fields:

NAME:

ADDRESS:

PHONE NUMBER:

RELATIONSHIP TO ENROLLEE:

Send completed application to:
CDPHP, Attn: Enrollment Operations, PO Box 31790, Rochester, NY 14603 1790

Office Use Only:

Plan ID#: _____

Effective Date of Coverage: _____

ICEP / IEP: _____ AEP / MA OEP: _____ SEP (type): _____

Name of staff member/agent/broker (if assisted in enrollment): _____ Not Eligible: _____

Section 2 - All 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.

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Please contact us if you would prefer us to send you information in a language other than English, or if you need information in an accessible format, other than what is listed above.

We can be reached at 1-888-248-6522 (TTY users call 711). Our office hours are Monday - Friday, 8:00 a.m. to 8:00 p.m. From October 1 through March 31, 8:00 a.m. to 8:00 p.m., 7 days a week.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP):

Please fill in your cell phone and/or email address.

Cell Phone Number:

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Email Address:

Electronic Communications

Please check the boxes for ALL forms of electronic communication you would like to receive:

☐ I would like to receive SMS notifications (text messages) from CDPHP. Message and data rates may apply.

☐ I would like Email notifications from CDPHP.

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 אידס און באדינונגס פֿאר פראווידינג 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 সহতা 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. Ndiheja të përshtatshme dhe shërbime shitesë 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.