

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 January 1)
- Between January 1 through March 31: The Medicare Advantage OEP is only for those beneficiaries who are enrolled in a Medicare Advantage Plan. These beneficiaries are allowed to make a one-time switch to a new plan.
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit [Medicare.gov](https://www.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. If you want to join during Medicare Advantage OEP (January 1–March 31) by switching from another plan the plan must get your completed form by March 31. 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:

Health First Health Plans
P.O. Box 62045
Phoenix, AZ 85082
Fax 833-582-2838

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

How do I get help with this form?

Call Health First Health Plans at 1.800.716.7737. TTY users can call 1-800-955-8771.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Health First Health Plans al 1.800.716.7737/TTY1-800-955-8771 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistir.



Health Plans

2022 Medicare Advantage Enrollment Request Form

Section 1 – All fields on this page are required (unless marked optional)**To enroll in Health First Health Plans, please provide the following information:****Select the plan you want to join:**

- Classic Plan (HMO-POS) \$97 per month Rewards Plan (HMO) \$0 per month
 Value Plan (HMO) \$33 per month Secure Plan (HMO) \$0 per month (no Part D Coverage)

FIRST name: _____ LAST name _____ Middle Initial: _____

Birth date: (MM/DD/YYYY) (___ / ___ / ___)	Sex: Male _____ Female _____	Phone number: ()
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Permanent Residence street address (Don't enter a PO Box): _____

City:	County:	State:	ZIP Code:
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Mailing address, if different from your permanent address (PO Box allowed): _____

City:	County:	State:	ZIP Code:
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Please provide your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section. <input type="checkbox"/> Fill out this information as it appears on your Medicare card. -OR- <input type="checkbox"/> Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	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.

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Health First Health Plans? Yes ___ No ___

Name of other coverage: _____

Member number for this coverage: _____

Group number for this coverage: _____

List your Primary Care Physician (PCP), clinic, or health center (if available): _____

List a unique identification number for your PCP (if available): _____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Health First Health Plans.
- By joining this Medicare Advantage Plan, I acknowledge that Health First Health Plans 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 Health First Health Plans coverage begins, I must get all of my medical and prescription drug benefits from Health First Health Plans. Benefits and services provided by Health First Health Plans and contained in my Health First Health Plans “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Health First Health Plans 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.

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): _____

NPN #: _____ Name of Agency or FMO (if applicable): _____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ OEP: _____ Not Eligible: _____

Date application received by agent/broker: _____

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.

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

Braille _____ Large print _____ Audio CD _____

Please contact Health First Health Plans at 1.800.716.7737 if you need information in an accessible format other than what's listed above. Our office hours are Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to noon. From October 1 to March 31, we're available seven days a week from 8 a.m. to 8 p.m. TTY users can call 1-800-955-8771.

Do you work? Yes _____ No _____ Does your spouse work? Yes _____ No _____

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.

Paying 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. 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 the RRB. DO NOT pay Health First HealthPlans the Part D-IRMAA.

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, check, money order, or online payments from your bank account or credit card 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.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible 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.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. 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 monthly invoices
- Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.
I get monthly benefits from: Social Security RRB

(The Social Security/RRB 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.)

You may also set up automatic payments from your Bank Account or Credit Card each month. Call Customer Service after you receive your Confirmation of Enrollment notification to set up payments. Automatic payments may also be set up through our online member portal at myHFHP.org/login.

**Information to include on or with Enrollment Mechanism –
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 enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) January 1st - March 31st.
- 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 an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity). One of the other statements here applied to me, but I was unable to make my enrollment *request* because of the disaster.

If none of these statements applies to you or you're not sure, please contact Health First Health Plans at 1.800.716.7737 (TTY users should call 1-800-955-8771) to see if you are eligible to enroll. We are open Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to noon. From October 1 to March 31, we're available seven days a week from 8 a.m. to 8 p.m.