L.A. Care Medicare Plus™
(HMO D-SNP)

Individual Enrollment Request Form to Enroll in a Medicare Advantage Plan (PART C)

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)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **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.
- 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:

L.A. Care Health Plan
Attn: Medicare Enrollment
1055 West 7th Street 10th Floor
Los Angeles, CA 90017

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

How do I get help with this form?

Call L.A. Care Health Plan at **1.833.592.3767**. TTY users can call **711**.
Or, call Medicare at **1-800-MEDICARE** (**1.800.633.4227**). TTY users can call **1.877.486.2048**.

En español: Llame a L.A. Care Health Plan al **1.833.592.3767** / TTY **711** o a Medicare gratis al **1.800.633.4227** y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

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

Select the plan you want to join:

☐ L.A. Care Medicare Plus (HMO D-SNP) – <$0> per month^

^This is a Dual Eligible Special Needs Plan. Your premium may be more if you are not receiving "Extra Help". Extra Help is a program to help people with limited income and resources pay Medicare prescription drug program costs, like premiums, deductibles, and coinsurance.

First Name:* _____ Last name:* _____ Midle Initial: _____

Birth date: (MM/DD/YYYY)*: _____ Sex:* ☐ Male ☐ Female

Phone number:* _____ Phone number type: ☐ Home ☐ Mobile

Secondary Phone number: _____ Secondary phone number type: ☐ Home ☐ Mobile

By checking these boxes you consent to allow L.A. Care to contact and communicate with you, including by calling or texting. You may change this consent at any time by contacting L.A. Care.

Permanent Residence street address (Don't enter a PO Box):*

_____

City: _____ Optional: County: _____

State:* _____ ZIP Code: * _____

Mailing address, if different from your permanent address (PO Box allowed):

_____

Street address: _____

City: _____ State:* _____ ZIP Code: * _____

Your Medicare information:

Medicare Number:* _ _ _ _ - _ _ _ _ - _ _ _ _

Optional: HOSPITAL (Part A): Effective Date: (MM/DD/YYYY)*: _____

Optional: MEDICAL (Part B): Effective Date: (MM/DD/YYYY)*: _____

Answer these important questions:

Are you enrolled in Medi-Cal?* YES ☐ NO ☐

If "Yes," please provide your Medi-Cal number: _____

Optional: Do you work? YES ☐ NO ☐ *Optional:* Are you Married? YES ☐ NO ☐

Optional: Does your spouse work? YES ☐ NO ☐

Will you have other health care coverage or prescription drug coverage (like employer, VA, TRICARE) in addition to L.A. Care Medicare Plus Plan?* YES ☐ NO ☐

Name of your plan (and employer, if applicable): _____

Effective Date of Other Coverage: _____ ID Number: _____

Group name: _____

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.

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
☐ **I choose not to answer.**
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Cuban

What's your race? *Select all that apply*.

☐ American Indian or Alaska Native
☐ Asian Indian
☐ Black or African American
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean
☐ Native Hawaiian
☐ Other Asian
☐ Other Pacific Islander
☐ Samoan
☐ Vietnamese
☐ White
☐ **I choose not to answer.**

Please select your verbal language preference, if other than English.

☐ Spanish ☐ Chinese ☐ Korean ☐ Armenian ☐ Russian ☐ Arabic
☐ Tagalog ☐ Vietnamese ☐ Farsi ☐ Khmer/Cambodian

Please select a language if you want us to send your Plan information in a language other than English.

☐ Spanish ☐ Chinese ☐ Korean ☐ Armenian ☐ Russian ☐ Arabic
☐ Tagalog ☐ Vietnamese ☐ Farsi ☐ Khmer/Cambodian

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

☐ Braille ☐ Large Print ☐ Audio CD ☐ Digital Audio File

Please contact L.A. Care Medicare Plus at **1.833.522.3767** if you need information in an accessible format other than what's listed above. Our office hours are 8am to 8pm 7 days a week. TTY users can call **711**.

Email address:

By providing your email address you consent to allow L.A. Care to contact and communicate with you by email. You will continue to receive Important Plan Information by Mail. You may change this consent at any time by contacting L.A. Care Medicare Plus at **1.833.522.3767** TTY **711**.

Please provide the information of your preferred Primary Care Physician (PCP)

Preferred
Health Provider name: _____ PCP Phone Number: _____

Preferred Health Provider address: _____

Medical Group/IPA: _____ L.A. Care Provider ID Number
(listed in provider directory): _____

Are you currently a patient of this doctor? YES ☐ NO ☐

Emergency contact full name: _____

Emergency
contact phone number: _____ Emergency
contact email: _____

Relationship to Beneficiary: _____

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).

☐ 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 L.A. Care Medicare Plus at **1.833.522.3767** (TTY users should call **711**) to see if you are eligible to enroll. We are open 8am to 8pm 7 days a week.

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 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.

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in L.A. Care Medicare Plus.
- By joining this Medicare Advantage, I acknowledge that L.A. Care Medicare Plus 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.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will
- automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my L.A. Care Medicare Plus coverage begins, I must get all of my medical
- and prescription drug benefits from L.A. Care Medicare Plus. Benefits and services provided by L.A. Care Medicare Plus and contained in my L.A. Care Medicare Plus "Evidence of Coverage / Member Handbook" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor L.A. Care Medicare Plus will pay for benefits or services that are not covered.
- 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 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:

Authorized Representative Name: _____

Authorized Representative Address: _____

Authorized Representative Phone Number: _____

Authorized Representative Relationship to Enrollee: _____

Agent Assistance Information:

Agent Name: _____ Agent License #: _____

Agent Phone Number: _____ Agent Email: _____

Agent Receipt Date: _____ Agent Proposed Effective Date of Coverage: _____