L.A. Care Medicare Plus
(HMO D-SNP)

OMB No. 0938-1378
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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 January1)
- 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: Product Sales / Agent Enrollment
1200 W. 7th Street, 2nd 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

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

Birth date: (MM/DD/YYYY) (/ /)	Sex: [ ] Male [ ] Female	Phone number: ( )	Phone number type: [ ] Home [ ] Mobile

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: - -

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to L.A. Care Medicare Plus?
[ ] Yes [ ] No

Name of other coverage: Member number for this coverage: Group number for this coverage:

Are you enrolled in Medi-Cal? [ ] Yes [ ] No	If "Yes", please provide your Medi-Cal Number:

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in L.A. Care Medicare Plus (HMO D-SNP).
- 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" 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:

Name:	Address:
Phone number:	Relationship to enrollee:

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.

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:
[ ] Asian Indian
[ ] Chinese
[ ] Filipino
[ ] Japanese
[ ] Korean
[ ] Vietnamese
[ ] Other Asian

[ ] Black or African American

Native Hawaiian and Pacific Islander:
[ ] Guamanian or Chamorro
[ ] Native Hawaiian
[ ] Samoan
[ ] Other Pacific Islander

[ ] White
[ ] **I choose not to answer**

Select your spoken language preference, if other than English.
[ ] Spanish [ ] Mandarin [ ] Cantonese [ ] Korean [ ] Armenian [ ] Russian [ ] Arabic
[ ] Tagalog [ ] Vietnamese [ ] Farsi [ ] Khmer/Cambodian

Select one if you want us to send you 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.
[ ] Large print [ ] Audio CD [ ] Data CD [ ] Braille

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. We are open 24 hours a day, 7 days a week, including holidays. TTY users can call 711 number.

Do you work? [ ] Yes [ ] No

Does your spouse work? [ ] Yes [ ] No

List your Primary Care Physician (PCP):

PCP Phone Number: ( )

PCP Address:

L.A. Care Provider ID Number (listed in provider directory):

Medical Group / IPA:

Are you currently a patient of this doctor?
[ ] Yes [ ] No

Secondary Phone Number: ( )

Phone number type: [ ] Home [ ] Mobile

[ ] By checking this box, 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.

E-mail address:

[ ] By checking this box, 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.

Emergency contact full name:	Emergency contact phone number: ( )
Emergency contact email:	Relationship to Beneficiary:

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.

Agent Assistance Information	
Agent Name:	Agent License #:
Agent Phone Number:	Agent Email Address:
Agent Receipt Date:	Agent Proposed Effective Date: