



CCHP

MEDICARE ADVANTAGE INDIVIDUAL ENROLLMENT REQUEST FORM

445 Grant Avenue, Suite 700, San Francisco, CA 94108 • Tel: (415) 955-8800 • Fax: (415) 955-8819 • www.cchphmo.com

Please contact CCHP at (415) 955-8800 if you need information in another language or format (Braille)

To Enroll in CCHP, Please Provide the Following Information

Please check which plan you want to enroll in:

- CCHP Senior Program (HMO) \$35.00 per month**
- Optional Supplemental Package Dental Plan \$14.60 per month**

- CCHP Senior Select Program (HMO SNP) \$0 per month**

LAST Name:	FIRST Name:	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Date of Birth (MM/DD/YYYY)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number ()	Alternate Phone Number ()
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Permanent Resident Street Address (P. O. Box is not allowed)

City:	State:	ZIP code:
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Mailing Address (only if different from your Permanent Residence Address):

Street Address:	City:	State:	Zip Code:
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Emergency Contact:	Phone Number:	Relationship to You:
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Email Address:

Please Provide your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blank so they match your red, white, and blue Medicare card.

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

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



SAMPLE ONLY

NAME _____

MEDICARE CLAIM NUMBER _____ SEX _____

IS ENTITLED TO _____ EFFECTIVE DATE _____

HOSPITAL (PART A) _____

MEDICAL (PART B) _____

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your plan premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

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 CCHP the Part D-IRMAA.

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 a bill Monthly

Electronic Funds Transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____ Account type: Checking Saving

Bank routing number: _____ Bank account number: _____

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (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)

Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD)? Yes No

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to this Plan? Yes No

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

Name of other coverage: _____

ID # for this coverage: _____ Group # for this coverage: _____

3. Are you 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) _____

4. Are you enrolled in Your State Medicaid program? Yes No

If yes, please provide your Medicaid number: _____. CCHP will verify your Medicaid eligibility. To be eligible for CCHP Senior Select (HMO SNP) you must have zero Share-of-Cost, full scope Medicaid.

If you answered No, you cannot enroll in CCHP Senior Select (HMO SNP).

5. Do you or your spouse work? Yes No

Please Choose a Primary Care Physician (PCP), clinic or health center:

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

Chinese Large Print

Please contact CCHP at 415-955-8800 if you need information in another format or language than what is listed above. Our office hours are seven days a week, 8:00 a.m. to 8:00 p.m. TTY users should call 1-877-681-8898.



Please Read This Important Information

If you currently have health coverage from an employer or union, joining this Medicare health plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join this Medicare health plan. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below

Note: “Plan” refers to the Medicare health plan that you selected on page 1 of the enrollment request form.

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

This Plan 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 be in only 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 or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get 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 when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

This Plan serves a specific service area. If I move out of the area that this Plan 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 this Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage (EOC) from this Plan 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 beginning on the date this Plan's coverage begins, I must get all of my health care from this Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by this Plan and other services contained in my Plan's Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THIS PLAN 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 CCHP, he/she may be paid based on my enrollment in CCHP.

Release of information: By joining this Medicare health plan, I acknowledge that CCHP will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that CCHP 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 are the authorized representative, you must sign above and complete the following information:

Name: _____

Address: _____

Phone Number: _____ **Relationship to Enrollee:** _____

Office Use Only

Name of staff member/agent/broker (if assisted in enrollment): _____ Date: _____

Effective Date of Coverage: _____

Plan ID: 001 005 006

Election Period: ICEP IEP AEP SEP

SEP Type: U – Dual Eligible/ LIS W – EGHP
 V – Permanent Move S – Other: _____

Member ID#: _____

