OMB No. 0938-1378 Expires: 7/31/2023



2022 Enrollment Request Form Use this form to enroll in a CoxHealth Medicare *Plus* plan

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 monthly invoice for the plan's premium and any applicable Late Enrollment Penalty. 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: CoxHealth Medicare*Plus* P.O. Box 12487 St. Louis, MO 63132

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

How do I get help with this form?

Call CoxHealth Medicare *Plus* at 1-866-509-5399. 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 CoxHealth Medicare *Plus* al 1-866-509-5399 (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.



Please contact CoxHealth Medicare Plus (HMO) Sales at 1-866-509-5399 if you need assistance completing this form. TTY users call the national relay service toll free at 711.

Section 1 - All fields on this page are required (unless marked optional)									
Select the plan you want to join:									
□ CoxHealth MedicarePlus (HMC)) 015 – (Southwest I	Missouri) \$0 per month							
FIRST Name: LAS	IRST Name: LAST Name:		Middle Initial (Optional):						
Birth Date:	Sex: Ph	none Number (select prima	ary phone number):						
(//)	□Male □	Mobile: ()							
(M M / D D / Y Y Y Y)	□ Female □	□ Home: ()							
Permanent Residence street add	County (Optional):								
City:		State:	Zip Code:						
Mailing Address, if different from your permanent address (PO Box allowed):									
Street Address									
City:		State:	Zip Code:						
E-mail address (Optional):									
Your Medicare Information									
Medicare Number:	Answer these in	nnortant questions:							
Answer these important questions: Will you have other prescription drug coverage (like VA, TRICARE) in addition to CoxHealth Medicare Plus? "Yes "No									
If "yes," please list your other coverage and your identification (ID) number(s) for this coverage.									
Name of other coverage:	for this coverage: Group	age: Group number for this coverage:							

IMPORTANT: Read and Sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in CoxHealth MedicarePlus.
- By joining this Medicare Advantage plan, I acknowledge that CoxHealth Medicare Plus will share my information with Medicare, who may use it to track my enrollment, and with other plans 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 CoxHealth Medicare Plus coverage begins, I must get all of my medical and prescription drug benefits from CoxHealth Medicare Plus. Benefits and services provided by CoxHealth Medicare Plus and contained in my CoxHealth Medicare Plus "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CoxHealth Medicare Plus will pay for benefits or services that are not covered. I will read the Evidence of Coverage document from CoxHealth Medicare Plus when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.
- Once I am a member of CoxHealth Medicare *Plus*, I understand that I have the right to appeal plan decisions about payment or services if I disagree.
- I understand that enrollment in CoxHealth Medicare *Plus* will automatically disenroll me from any other Medicare health plan and/or prescription drug plan.

Medicare health plan and/or prescription drug 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 a		• • •	reation. If signed by an							
1) This person is authorized under	•		and							
2) Documentation of this authority is available upon request by Medicare.										
Signature:	Today's	Today's Date:								
If you are the authorized representative, sign	above and fill out these	e fields:								
Name:	Relationship to Enrol	lee: Phon	Phone Number:							
Address:	City:	State	: Zip Code:							
Section 2 - All fields on 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 infor	mation in a language o	ther than Engli	 ish.							
□ Spanish □ Polish □ Chinese □ Arabic □ N		3								
Select one if you want us to send you infor	mation in an accessibl	e format								
□ Braille □ Large Print	mation in an accession	c format.								
Please contact CoxHealth MedicarePlus at 1-	866-509-5399 if you nee	d information in	n an accessible format							
or language other than what's listed above. (Our office hours are 8:00	a.m. to 8:00 p.n	n., 7 days a week. You							
may receive a messaging service on weekend can call 711.	ls from April 1 through S	September 30 ar	nd holidays. TTY users							
List your primary care physician (PCP), clinic or health center:										
Primary Care Physician (PCP):										
Dr.		physicia								

(First Name)

(Last Name)



PLEASE READ THIS IMPORTANT INFORMATION



If you currently have health coverage from an employer or union, joining CoxHealth Medicare *Plus* could affect your employer or union health benefits. You could lose your employer or union health coverage if you join CoxHealth Medicare *Plus*. 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.

Paying your plan premiums

Whether you are enrolled in a premium or non-premium plan, you may pay your plan premium and any applicable Late Enrollment Penalty that you have or may owe **by automatic deduction from your Social Security (SSA) or Railroad Retirement Board (RRB) benefit check**. You may also choose to pay by Electronic Funds Transfer (EFT) from your bank, Credit card, Debit card, or check via mail each month.

If you have to pay a Part-D Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security Benefit, or you may get a bill from Medicare (or the RRB). DON'T pay CoxHealth Medicare Plus 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 do not select one of the payment options below, you will receive a monthly invoice. Please select a premium payment option:

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.							
I get monthly benefits from: Social Security RRB							
It can take up to 90 days to receive SSA/RRB withhold acceptance. SSA/RRB will begin deducting on the date of acceptance. Members will receive an invoice for any months prior to the withhold acceptance date by SSA/RRB, which will be their responsibility to pay. In limited circumstances, Medicare may not allow for the SSA/RRB deduction option and may instruct the plan to directly bill the member. If this occurs, you will be notified in writing.							
Electronic Funds Transfer (EFT) from your bank account each month.							
If you choose to have the funds taken directly out of your checking account, this is referred to as Electronic Funds Transfer (EFT). If you elect this method of payment, you will receive a letter from the plan requesting a Voided Check be returned with the letter for account setup. Do not submit a voided check at time of enrollment. Your request will be processed within 60 business days of receipt of returned voided check and letter. Premiums are deducted from your bank account on the 2 nd day of the month for the current month's coverage.							
Direct Pay							
You will receive a monthly invoice containing payment instructions.							

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.

FOR OFFICE USE ONLY									
Confirmation # (Q	Application Log #:								
			_						
Plan ID #:			Effective Date of Coverage:						
Election									
Periods:	□ ICEP (I)	□ IEP (E)	□ 2 nd IEP (F)	□ AEP (A)	□ OEP (M)	□ OEPI (T)			
Special Election P	eriods : (Must cl	neck all that app	oly)						
SEP (S)			SEP (V)						
☐ SPAP (38)			□ P	ermanent Mov	е				
☐ Loss of SNI									
☐ Retro Entit	• •		SEP (W)						
	y Loss/Cred. Co	• , ,	☐ Gain or Loss of Employer Coverage						
•	lan Non-Renew	al (12)							
☐ Contract V			SEP (L) Allowed once per Quarter						
☐ Contract Term – Immediate (11)			☐ Dual Eligible/Has Medicaid						
☐ Contract Term – MAO (12)			☐ Has Non-Dual with LIS						
☐ Contract Term – CMS (11)			SEP (U)						
☐ CMS Sanction (23)			☐ Gain/Loss/Change in Dual Eligible Status						
☐ FEMA/Disaster (01)			☐ Gain/Loss/Change of Medicaid☐ Gain/Loss/Change in Non-Dual LIS						
☐ Plan Placed in Receivership (39)			, , ,						
 CMS Identified Consistent Poor Performing Plan (40) 			g SEP (R) □ 5-Star SEP						
, ,	Format Delay (21)		-Star SEr					
	☐ Accessible Format Delay (21)								
☐ Inv. Dis. – Loss of Part B (25)									
	□ PACE Transition (27)□ Cost Plan Non-Renewal (28)								
☐ Drop Medigap in Trial Period (29)									
☐ Additional									
□ Part B Gen									
☐ Lawfully Present (37)									
☐ COVID-19 Disaster (02)									
Producer Name:	, , ,		Producer N	IPN:	Applicatio	n Receipt			
					Date:	-			



Please return completed application to:

CoxHealth Medicare*Plus* P.O. Box 12487 St. Louis, MO 63132

Please call 1-866-509-5399 for more information, including free language translation services, regarding your CoxHealth Medicare Plus plan. TTY users call the national relay service toll free at 711. Our telephone lines are open 7 days a week from 8:00 a.m. to 8:00 p.m. You may receive a messaging service on weekends from April 1 through September 30 and holidays. Please leave a message and your call will be returned the next business day. CoxHealth Medicare Plus is an HMO plan with a Medicare contract. Enrollment in CoxHealth Medicare Plus depends on contract renewal. You must continue to pay your Medicare Part B premium.