OMB No. 0938-1378; Expires: 07/31/2024

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.

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.

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:

Western Health Advantage Mail Service
Attn: Membership Accounting
P.O. Box 14952
Salem, OR 97309

Scan and fax pages to: 916.678.5441

Scan and email pages to:
MAEnrollment@westernhealth.com

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

How do I get help with this form?

Call Western Health Advantage at 916.246.7494 or 888.992.7494. 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 Western Health Advantage al 916.246.7494 or 888.992.7494/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.

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

Select the **Western Health Advantage** MyCare plan you want to join:

☐ **WHA MyCare (HMO)** — $0 per month — Available for Napa, Marin, Sacramento, Sonoma, Solano, and Yolo counties

☐ **WHA MyCare Compass (HMO)** — $20 per month — Available for Humboldt County

FIRST name _____ LAST name _____ MIDDLE initial (optional) _____

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

Phone Number (_____)_____–_____

Permanent Residence street address (Do not enter a PO Box) _____

City _____ County _____ State _____ Zip Code _____

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

City _____ State _____ Zip Code _____

Email Address _____

Your Medicare information:

Medicare Number ____ ____ ____ ____–____ ____ ____–____ ____ ____ ____

Answer these important questions:

Will you have other prescription coverage in addition to Western Health Advantage? ☐Yes ☐No

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

Name of other coverage _____

Member number for this coverage _____ Group number for this coverage _____

IMPORTANT – Read and sign below:

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

_____ _____

Address Relationship to Enrollee

AGENT USE ONLY

_____ _____/_____/_____

Agent or Agency Name Date

_____ (_____)_____– _____ _____

Agent or Agency WHA ID# Agent Phone Number Agent Email Address

_____/_____/_____ _____/_____/_____

Date Application Received by Agent Requested Date of Coverage

Agent Signature: _____

With my signature, I hereby certify that I have read and understand the CMS Medicare Communications and Marketing Guidelines and Enrollment rules and confirm the enrollee has received a complete enrollment kit. I agree that this enrollment of a Medicare beneficiary has complied with these rules.

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, Mexican, Mexican American, Chicano/a
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ I choose not to answer.

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.

Do you want us to send your information in Spanish? ☐ Yes ☐ No

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

☐ Braille ☐ Large print ☐ Audio CD

Please contact Western Health Advantage at 888.942.4777 if you need information in an accessible format other than what's listed above. We are open 8 a.m. to 8 p.m., seven days a week, October–March, and 8 a.m. to 8 p.m., Monday–Friday, April–September. TTY users can call 711.

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

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

_____

WHA Provider ID # _____ Medical Group _____

Are you an existing patient of this provider? ☐ Yes ☐ No

Section 2 (cont.) – All fields on this page are optional

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit 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 Western Health Advantage the Part D-IRMAA.

Please select a premium payment option:

☐ Get a monthly bill – Once you receive your first bill, you can choose a different payment option:

- You can pay by credit/debit card or checking/savings account: One-time or recurring payments can be made via your myWHA account at mywha.org/MyCareLogin.
- You can pay by phone: Self Service is available 24 hours a day, 7 days a week, at 844.343.1318, TTY: 711.

☐ 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. You may receive an invoice for the first few months before the withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a letter and paper bill for your monthly premiums.)

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

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 leaving employer or union coverage 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 am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) (January 1-March 31).

☐ 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 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 belong to a pharmacy assistance program provided by my state.

☐ I recently left a PACE program on (insert date): _____ /_____ /_____

☐ 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 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): _____ /_____ /_____

continued on next page

Attestation of Eligibility for an Enrollment Period (continued)

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date): _____ /_____ /_____

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ 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 the facility on (insert date): _____ /_____ /_____

I moved/will move out of the facility 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 because of the disaster.

If none of these statements applies to you or you're not sure, please contact Western Health Advantage at 916.246.7494 or 888.992.7494 (TTY users should call 711) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., seven days a week, October–March and 8 a.m. to 8 p.m., Monday–Friday, April–September.