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?

Submit your completed and signed form using one of the three options below:

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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT: Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

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

Select the plan you want to join:

Available for Napa, Marin, Sacramento, Sonoma, Solano, and Yolo counties:

- ☐ Western Health Advantage **MyCare** (HMO) - $0 per month
- ☐ Western Health Advantage **MyCare Plus** (HMO) - $85 per month

Available for Humboldt county:

- ☐ Western Health Advantage **MyCare Compass** (HMO) - $20 per month

FIRST name ____________ LAST name ____________ MIDDLE initial ____

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? Some individuals may have other coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State pharmaceutical assistance programs. ☐ 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 or Medicare Prescription Drug 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.

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

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, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ 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 888.563.2250 or 916.563.2250 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 through March and 8 a.m. to 8 p.m., Monday-Friday, April through September. TTY users can call 711.

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

List your Primary Care Provider (PCP) name and/or ID number:

____

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 enrolling during the Annual Enrollment Period (October 15-December 7) or Special Enrollment Period.
- ☐ 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 received notice of a Medicare entitlement determination for a retroactive effective date. I was notified 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): ______/______/______
- ☐ 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 (insert date): ______/______/______
- ☐ Medicare is ending its contract with my plan (insert date): ______/______/______
- ☐ I was impacted by a significant network change with my current plan and was notified 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 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 you checked this box, please provide the following information:

  Name of disaster: ______________________

  Eligibility period missed (for example: initial enrollment period, annual enrollment period, open enrollment period, or special enrollment period): ______________________

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 through March and 8 a.m. to 6 p.m., Monday-Friday, April through September.