



## Medicare Advantage 2026 Individual Enrollment Application

### 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](https://www.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:

Independent Health  
Attn: Membership, Government Operations  
P.O. Box 610  
Williamsville, NY 14231-9909

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

### How do I get help with this form?

Call Independent Health at (716) 635-4900 or 1-800-958-4405 toll-free. 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 Independent Health al (716) 635-4900 o 1-800-958-4405 TTY: 711 o a Medicare gratis al 1-800-633-4227 y oprima el 8 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.

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:**

- Independent Health’s Encompass 65® RED 042 HMO (with prescription coverage) H3362-042: \$40 monthly premium
- Independent Health’s Encompass 65® RED 044 HMO (with prescription coverage) H3362-044: \$95 monthly premium
- Independent Health’s Encompass 65® RED 043 HMO (with prescription coverage) H3362-043: \$190 monthly premium
- Independent Health’s Medicare Passport® Connect PPO (with prescription coverage) H3344-013: \$58.80 monthly premium
- Independent Health’s Encompass 65® HMO (without prescription coverage; with an \$11 Part B Premium Reduction) H3362-016: \$0 monthly premium

FIRST name: \_\_\_\_\_ LAST name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Birth date: (MM/DD/YYYY) ( _____ / _____ / _____ )	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone number: ( _____ )
---	---	----------------------------

Permanent Residence street address (Don’t enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City: \_\_\_\_\_ 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 Independent Health?  
 Yes  No

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 Independent Health.
- By joining this Medicare Advantage Plan, I acknowledge that Independent Health 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 Independent Health coverage begins, I must get all of my medical and prescription drug benefits from Independent Health. Benefits and services provided by Independent Health and contained in my Independent Health “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Independent Health 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.



## 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
- Electronic Fund Transfer from your checking account each month (Please include a voided check with this application)
- Enroll in paperless billing
- Credit card each month

You can also choose to pay your premium by having it automatically taken out of your

- Social Security Check each month or;
- Railroad Retirement Board (RRB) benefit each month

(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.) If you enrolled in the EPIC fee plan, we recommend not selecting Social Security Deduction or EFT.

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 Independent Health the Part D-IRMAA.

### For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: \_\_\_\_\_ Relationship to enrollee: \_\_\_\_\_  
Signature: \_\_\_\_\_ National Producer Number (Agents/Brokers only): \_\_\_\_\_

**OFFICE USE ONLY** Name of staff member/agent/broker (if assisted in enrollment): \_\_\_\_\_  
Effective Date of Coverage: \_\_\_\_\_ Location: \_\_\_\_\_  
Plan ID #: \_\_\_\_\_ ICEP/IEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP (type): \_\_\_\_\_ OEP: \_\_\_\_\_ OSD: \_\_\_\_\_

#### 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.