



Medicare Advantage 2027 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: \$49 monthly premium
- ☐ Independent Health's Encompass 65® RED 044 HMO (with prescription coverage) H3362-044: \$110 monthly premium
- ☐ Independent Health's Encompass 65® RED 045 HMO (with prescription coverage) H3362-043: \$286 monthly premium
- ☐ Independent Health's Medicare Passport® Connect PPO (with prescription coverage) H3344-013: \$81 monthly premium
- ☐ Independent Health's Encompass 65® HMO (without prescription coverage; with a \$60 Part B give back) H3362-016: \$0 monthly premium

FIRST name:

LAST name:

Middle Initial:

Birth date: (MM/DD/YYYY)

Sex:

☐ Male ☐ Female

Phone number:

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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.

- 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:

Address:

Phone number:

Relationship to enrollee:

Section 2 – All fields in 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 information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Independent Health at (716) 250-4401 or 1-800-665-1502 if you need information in an accessible format other than what's listed above. Our office hours are October 1 – March 31: Monday – Sunday, 8 a.m. – 8 p.m.; April 1- September 30: Monday – Friday, 8a.m.- 8p.m. 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:

Email Communications

By checking the box(es) below and providing my email address, I agree to receive the following documents and notifications electronically from Independent Health.

Email Address: _____

☐ Annual Notice of Change

☐ Part C and Part D (if applicable) Explanation of Benefits

☐ Communications related to plan details, status or transactions, promotional activities, health and wellness recommendations, health education and other information.

Text Messaging and Automated Phone Call Communications

By checking the box(es) below and providing my phone number, I expressly consent to receiving from Independent Health, its affiliates, and agents automated messages, including SMS/Text messages, phone calls using automated telephone dialer systems, or prerecorded voice or artificial voice messages at the number provided. Consent is not required as a condition of coverage. You may opt out of receiving these messages at any time by replying STOP to opt out of text messaging or calling Independent Health at 716-250-4401.

Mobile Phone Number: _____

I agree to receive the following from Independent Health regarding communications related to plan details, status or transactions, promotional activities, health and wellness recommendations, health education and other information.

☐ Automated Phone Calls

☐ Text Messages

Some messages may include health information that's specific to you. If you choose to receive emails and/or text messages, please know that electronic communication isn't always secure. There's a small risk that your messages could be seen or intercepted by someone else. By opting in, you understand and accept this risk. Message and data rates may apply.

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.

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 enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and have new options available to 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 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 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 have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).
- ☐ 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/out of the facility on *(insert date)* _____.
- ☐ I recently left a PACE program 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)* _____.
- ☐ I am leaving employer or union coverage on *(insert date)* _____.
- ☐ I'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ 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 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 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 request because of the natural disaster.

If none of these statements apply to you or you are not sure, please contact Independent Health to see if you are eligible to enroll: **(716) 635-4900** or **1-800-958-4405** (TTY users should call 711), October 1 – March 31: Monday – Sunday, 8 a.m. – 8 p.m.; April 1 – September 30: Monday – Friday, 8 a.m. – 8 p.m.

Independent Health is a Medicare Advantage organization with a Medicare contract offering HMO, HMO-SNP, HMO-POS and PPO plans. Enrollment in Independent Health depends on contract renewal.



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