OMB No. 0938-1378 Expires 7/31/2024

2024 Individual Enrollment Application

For MVP Health Care® Medicare Advantage Health Plans

Rochester/Buffalo Region

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

To join a Medicare Advantage Plan, you must also have both Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance).

When do I use this form?

You can join a plan:

- October 15–December 7 each year (for coverage starting January 1)
- Within three 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

You must complete all items in Sections 1–8, unless otherwise noted.

Things you should remember.

- 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:

MVP Medicare Enrollment
MVP Health Care
20 S Clinton Ave
Rochester NY 14604-1793

Once MVP processes your request to join, they will contact you.

How do I get help with this form?

Call MVP Health Care at **1-800-324-3899**.
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 MVP Health Care al **1-800-324-3899** (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.

MVP Health Plan, Inc. is an HMO-POS/PPO organization with a Medicare contract.
Enrollment in MVP Health Plan depends on contract renewal.

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.

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Please complete Sections 1–8. Complete one enrollment application per applicant.

Please contact the MVP Medicare Customer Care Center at **1-800-665-7924** (TTY 711) if you need information in a language other than English, or in an accessible format. Call seven days a week, 8 am–8 pm Eastern Time. April 1–September 30, call Monday–Friday, 8 am–8 pm.

Section 1: Select the Plan in Which You Want to Enroll

☐ **MVP Medicare Gold Giveback with Part D (PPO)**	**$0** monthly premium
☐ **MVP Medicare Preferred Gold® without Part D (HMO-POS)**	**$0** monthly premium
☐ **MVP Medicare Secure® with Part D (HMO-POS)**	**$25** monthly premium
☐ **MVP Medicare Patriot Plan® with Part D (PPO)**	**$40.20** monthly premium
☐ **MVP Medicare WellSelect® with Part D (PPO)**	**$86.40** monthly premium
☐ **MVP Medicare Preferred Gold® with Part D (HMO-POS)**	**$222.40** monthly premium

Section 2: Information About Yourself *(please print)*

Name *(Last, First, Middle Initial)*

Gender ☐ **Male** ☐ **Female**

Date of Birth

Preferred Residence Street Address *(PO Box is not allowed)*

Preferred Phone No.

City

State

Zip Code

County

Mailing Address *(if different from Permanent Address)*

City

State

Zip Code

MVP Member ID No. *(if a current MVP Medicare Member)*

Preferred Email Address *(optional)*

Are you of any of the following origins? *(select all that apply)*

Answering this question is your choice. You cannot be denied coverage if you don't select an answer.

- ☐ **Mexican, Mexican American, Chicano/Chicana**
- ☐ **Puerto Rican**
- ☐ **Cuban**
- ☐ **Other Hispanic, Latino/Latina, or Spanish**
- ☐ **Not of any of the listed origins**
- ☐ **I choose not to answer**

Member Name *Medicare Member ID No.*

*(**Section 2: Information About Yourself** continued)*

What is your race? *(select all that apply)*

Answering this question is your choice. You cannot be denied coverage if you don't select an answer.

- ☐ **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**

Section 3: Your Medicare Number

The following can be found on your red, white, and blue Medicare card.

Your Medicare Number (XXXX-XXX-XXXX)

Effective Dates

Hospital (Part A) Medical (Part B)

Section 4: Your Primary Care Physician (PCP)

If you are enrolling in WellSelect or Patriot Plan, you are not required to complete this step.

PCP's Full Name

Are you an existing patient?

☐ **Yes** ☐ **No**

Section 5: How You Will Pay Your Plan Premium

Select the payment method below for your monthly premium and/or any late enrollment penalty you may owe. **If you do not select a payment option, MVP will bill you monthly.**

- ☐ **Bill me monthly** (once enrolled, you can register for an MVP online account and pay your bill online).
- ☐ **Automatically deduct my premium** from my monthly Social Security benefit check.*
- ☐ **Automatically deduct my premium** from my monthly Railroad Retirement Board benefit check.*
- ☐ **The plan I chose has no monthly premium.**

**The first automatic deduction may take several months to begin. Continue to pay your bill until the deduction starts.*

If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA) by Medicare, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check, or be billed directly by Medicare or the Railroad Retirement Board. Do not pay MVP the Part D-IRMAA.

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, MVP will bill you for the amount that Medicare does not cover. For information about the Extra Help program, visit **ssa.gov/medicare** and select *Apply for Part D Extra Help*.

Member Name *Medicare Member ID No.*

Section 6: Read and Provide Answers to the Following Questions *(please print)*

1. Will you have other prescription drug coverage in addition to MVP? ☐ **Yes** ☐ **No**
Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or EPIC (NY).

If you answered ***Yes***, refer to the ID card for your other drug coverage and provide the following:

Name of Other Coverage	Rx ID No.	Rx Group No.

Your answers to the following questions are optional.
You can't be denied coverage because you did not answer them.

2. Are you enrolled in your State's Medicaid program ☐ **Yes** (Your Medicaid No. _____) ☐ **No**

3. Do you or your spouse work? ☐ **Yes** ☐ **No**

4. Have you served in the military? ☐ **Yes** ☐ **No**

Section 7: Reason for Enrolling

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period, October 15–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 Medicare later determines that this information is incorrect, you may be disenrolled.

☐ This is my selection for Annual Enrollment.

☐ I am new to Medicare or I had Medicare before, but I am now turning 65.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period.

☐ I am leaving employer or union coverage on (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 belong to a pharmacy assistance program provided by my state, or EPIC (NY).

☐ 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 (date) _____.

☐ I recently had a change in my Medicaid (started receiving Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (date) _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (started receiving Extra Help or lost Extra Help) on (date) _____.

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

Member Name *Medicare Member ID No.*

*(**Section 7: Reason for Enrolling** continued)*

- ☐ 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 (date) _____.
- ☐ My current plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ 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 (date) _____.
- ☐ I recently was released from incarceration. I was released on (date) _____.
- ☐ I recently obtained lawful presence status in the United States on (date) _____.
- ☐ 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) on (date) _____.
- ☐ I recently left a PACE program on (date) _____.
- ☐ After living permanently outside of the United States, I recently returned to the U.S. on (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 disaster.
- ☐ My current plan has been placed into receivership.
- ☐ I was granted a Special Enrollment Period due to exceptional circumstances as determined by Medicare.
- ☐ I was enrolled in a plan that has been identified by CMS as a consistent poor performer in the Medicare Star Ratings.
- ☐ I am enrolling into a 5-star plan.
- ☐ None of these statements applies to me. Please contact MVP to see if you are eligible to enroll. Call **1-800-324-3899** seven days a week, 8 am–8 pm Eastern Time. April 1–September 30, call Monday–Friday, 8 am–8 pm. (TTY 711).

Section 8: Your Signature and Authorization

Release of information: By joining this Medicare health plan, I acknowledge and consent to the release, use, and disclosure of my information (which may include prescription information, medical information, HIV, mental health, and/or alcohol and substance abuse information) by MVP Health Care® (MVP) or any health care provider involved in caring for me to Medicare, MVP, or any health care providers, or organizations involved in my care, and other plans as is reasonably necessary for MVP or my health care providers to carry out treatment, payment, or health care operations, or as otherwise and to the extent permitted by, and in accordance with, applicable laws, regulations, and rules. I also acknowledge that MVP may release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes—to the extent permitted by, and in accordance with, applicable laws, regulations, and rules.

By signing below, I understand that:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in an MVP Medicare Advantage Plan.
- By joining this Medicare Advantage Plan, I acknowledge that MVP 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 on the cover page of this form).

Member Name *Medicare Member ID No.*

*(**Section 8: Your Signature and Authorization** continued)*

- Your response to this form is voluntary. However, failure to respond may affect your 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.
- By providing my email address, I give permission for MVP to send me emails related to my plan and benefits. I understand that I am entitled to receive paper documents, and that I can set and change my communication preferences at any time by signing in at **my.mvphealthcare.com** and selecting *Communication Preferences* or by calling MVP at **1-800-TALK-MVP** (1-800-825-5687).
- I understand that when my MVP Health Care coverage begins, I must get all of my medical and prescription drug benefits from MVP. Benefits and services provided by MVP and contained in my MVP Health Care "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor MVP 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 are the authorized representative, sign above and provide the information below about yourself.

Name	Relationship to Enrollee	Preferred Phone No.

Street Address	City	State	Zip Code

Office Use Only

Name of Staff Member/Agent/Broker *(if assisted in enrollment)*			Plan ID No.	Effective Date of Coverage
ICEP/IEP	AEP	SEP (type)	Not Eligible	Agent License No.

Paperwork Reduction Act Disclosure Statement

According to the Paperwork Reduction Act of 1995 (PRA), 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-NEW. 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 Blvd, 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 the cover page to send your completed form to the plan.