

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](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:
RiverSpring Health Plans
80 West 225th Street
Bronx, NY 10463

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

How do I get help with this form?

Call RiverSpring Health Plans at 1-800-771-0088. 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 RiverSpring Health Plans al 1-800-771-0088 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.

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-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 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.

RiverSpring Health Plans ENROLLMENT REQUEST FORM

SECTION 1 All Fields on this page are required (unless marked optional)

To Enroll in RiverSpring Health Plans, Please Provide the Following Information:

- RiverSpring Star (HMO I-SNP) \$26.30 premium per month
 RiverSpring MAP (HMO D-SNP) \$0.00 premium per month

Personal Information

Last Name: _____ First Name: _____

Mr. Mrs. Ms. Sex: M F Middle Initial (optional): _____

Birth Date: (MM/DD/YYYY)
(__ __ / __ __ / __ __ __ __)

Home Phone Number: _____

Alternate Phone Number (optional): _____

E-mail Address (optional): _____

Permanent Residence

Street Address (P.O. Box is not allowed): _____

City: _____ County (optional): _____ State: _____ ZIP Code: _____

Mailing Address (only if different from your Permanent Residence Address):

Street Address (P.O. Box is not allowed): _____

City: _____ County (optional): _____ State: _____ ZIP Code: _____

Emergency Contact

Name: _____

Phone Number: _____ Relationship to You: _____

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Name: (as it appears on your Medicare card) _____

Medicare Number: _____

Effective Date:

Hospital (Part A) _____

Medical (Part B): _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

1. Some individuals may have other drug coverage, including other private insurance, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to RiverSpring Health Plans?

Yes No

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

Name of Other Coverage: _____

ID# for this Coverage: _____ Group # for this Coverage: _____

2. Are you a resident of a long-term care facility, such as a nursing home?

Yes No

If "Yes," please provide the following information:

Name of Institution: _____

Address & Phone Number of Institution (number and street) _____

3. Please indicate if you meet all of the following requirements.

You are eligible for full New York State Medicaid coverage,

Yes No

You are 18 years or older

Yes No

You believe you are eligible for a nursing home level of care, are capable of safely remaining in your home, and require care management and home care or day care services for 120 continued days or longer?

Yes No

4. Are you enrolled in your State Medicaid Program?

Yes No

If "Yes," please provide your Medicaid (CIN) number: _____

SECTION 2 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.

- | | |
|---|---|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican | <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin |
| <input type="checkbox"/> Yes, Cuban | <input type="checkbox"/> I choose not to answer. |

What is your race? Select all that apply.

- | | | |
|---|--|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Korean | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> White |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Other Asian | <input type="checkbox"/> I choose not to answer. |

What is your gender? Select one.

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Woman | <input type="checkbox"/> I use a different term: _____ |
| <input type="checkbox"/> Man | <input type="checkbox"/> I choose not to answer |
| <input type="checkbox"/> Non-binary | |

Which of the following best represents how you think of yourself? Select one.

- | | |
|--|--|
| <input type="checkbox"/> Lesbian or gay | <input type="checkbox"/> I use a different term: _____ |
| <input type="checkbox"/> Straight, that is, not gay or lesbian | <input type="checkbox"/> I don't know |
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> I choose not to answer |

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

- Spanish Chinese Russian Large Print Braille Audio CD Data CD
 Other: _____

Please contact RiverSpring Health Plans at 1-800-771-0088 if you need information in an accessible format or language than what is listed above. Our office hours are 8 a.m. to 8 p.m. 7 days a week. TTY users should call 711.

Do you or your spouse work?

- Yes No

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

Name: _____

Address: _____

I want to get the following materials via email. Select one or more:

- Summary of Benefits Evidence of Coverage Annual Notice of Change Formulary

E-mail address: _____

PAYING YOUR PLAN PREMIUM

You can pay your plans premium (including any late enrollment penalty that you currently have or may owe) by Mail, Electronic Funds Transfer (ETF) or credit card. 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.

Please select a premium payment option:

- Get a bill

- Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.
I get monthly benefits from: Social Security RRB

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 (River Spring Health Plans) the Part D-IRMAA.

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.

By completing this enrollment application, I agree to the following:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in RiverSpring Health Plans.
- By joining this Medicare Advantage Plan, I acknowledge that RiverSpring Health Plans 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 or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my RiverSpring Health Plans coverage begins, I must get all of my medical and prescription drug benefits from RiverSpring Health Plans. Benefits and services provided by RiverSpring Health Plans and contained in my RiverSpring Health Plan’s “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor RiverSpring Health Plans 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: _____ Date: _____

* If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number _____

Relationship to Enrollee: _____

FOR RIVERSPRING HEALTH PLANS USE ONLY

Date Received: _____ Plan ID: _____

QMB QMB+ SLMB SLMB+ QI-1 QDWI FBDE

Name of Staff member (if assisted in enrollment): _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ OEPI: _____

Not Eligible: _____

LICENSED AGENT USE ONLY

I certify that I have truly and accurately recorded on this application the information supplied by the enrollee.

Licensed Agent: _____

Agent License #: _____

Date Received: _____ Agent Signature: _____

ElderServe Health, Inc.
80 West 225th Street
Bronx, New York 10463
Telephone: (800) 362-2266

INFORMATION TO INCLUDE ON OR WITH ENROLLMENT MECHANISM – 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 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 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 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/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 belong to a pharmacy assistance program provided by my state.

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 a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact RiverSpring MAP at 1-800-362-2266 (TTY users should call 711) to see if you are eligible to enroll. We are open 7 days a week from 8 a.m. to 8 p.m. ET.

Thank you.

Sincerely,



Elina Krugolets, RN, BSN
Vice President of Intake