ElderServe Health™

OMB No. 0938-1378 Expires:02/28/2029

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 either, or 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.

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:
ElderServe Health
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 ElderServe Health 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 ElderServe Health 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.

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ENROLLMENT REQUEST FORM

SECTION 1 **All Fields on this page are required (unless marked optional)**
To Enroll in ElderServe Health, Please Provide the Following Information:

☐ ElderServe Star (HMO I-SNP) <$22.00> premium per month
☐ ElderServe 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 adress (Don't enter a PO Box. Note: For individuals experiencing homelessness, a P.O Box may be considered your permanent address.)

Street Address: _____

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

Mailing Address, if different from your permanent residence address (PO Box Allowed):

Street Address: _____

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

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

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

Medicare Number: _____

Effective Date:

☐ Hospital (Part A) _____

☐ Medical (Part B): _____

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PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS:

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 ElderServe Health?
   ☐ 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 and the following minimum need:
   - at least limited assistance with physical maneuvering with more than two activities of daily living (ADLs); or
   - individuals with a Dementia or Alzheimer's diagnosis, assessed as needing at least supervision with more than one ADL"

   ☐ Yes ☐ No

4. Are you enrolled in your State Medicaid Program?
   ☐ Yes ☐ No

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

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PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS:

Section 2 **Answering these questions is your choice.You can't be denied coverage because you don't fill them out.**

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

☐ Accessible Format (Braille, Audio CD, Data CD, or Large Print): _____

Please contact ElderServe Health at 1-800-771-0088 if you need information in an accessible format or language other 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

Email Address: _____

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PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS:

PAYING YOUR PLAN

You can pay your plans premium (including any late enrollment penalty that you currently have or may owe) by Mail. 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 by mail

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

☐ 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 ElderServe 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.

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IMPORTANT: PLEASE READ AND SIGN BELOW

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

- I must keep both Hospital (Part A) and Medical (Part B) to stay in ElderServe Health.
- By joining this Medicare Advantage Plan, I acknowledge that ElderServe 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 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 ElderServe Health coverage begins, I must get all of my medical and prescription drug benefits from ElderServe Health. Benefits and services provided by ElderServe Health and contained in my ElderServe Health's "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor ElderServe 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: _____ Date: _____

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

Name: _____

Address: _____

Phone Number _____

Relationship to Enrollee: _____

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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):_____

FOR ELDERSERVE HEALTH PLANS USE ONLY

Date Received: _____ Plan ID: _____

☐ QMB ☐ QMB+ ☐ SLMB ☐ SLMB+ ☐ QI-1 ☐ QDWI ☐ FBDE

Effective Date of Coverage: _____

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

Not Eligible: _____

ElderServe Health™

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 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 disaster.

If none of these statements applies to you or you're not sure, please contact ElderServe 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

ElderServe Health, Inc. Notice of Nondiscrimination

ElderServe Health, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR CFR § 92.101(a)(2)). ElderServe Health, Inc. does not exclude people or treat them less favorable because of race, color, national origin, age, disability, or sex.

ElderServe Health, Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, which may include:
    - Qualified interpreters
    - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Civil Rights Coordinator. If you believe that ElderServe Health, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you may file a grievance with:

ElderServe Health
ATTN Civil Rights Coordinator
80 West 225th Street
Bronx, NY, 10463

Phone: 1-800-771-0088, TTY 711
Fax: 1-888-341-5009

You may file a grievance in person or by mail, phone, or fax. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATTENTION: Language assistance services and other aids, free of charge, are available to you. Call 800-362-2266 TTY:711.	English
ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis. Llame al 800-362-2266 TTY:711.	Spanish
请注意：您可以免费获得语言协助服务和其他辅助服务。请致电 800-362-2266 TTY:711。	Chinese
ملاحظة: خدمات المساعدة اللغوية والمساعدات الأخرى المجانية متاحة لك. اتصل بالرقم 800-362-2266 TTY:711.	Arabic
주의: 언어 지원 서비스 및 기타 지원을 무료로 이용하실 수 있습니다. 800-362-2266 TTY:711 번으로 연락해 주십시오.	Korean
ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика и другие виды помощи. Звоните по номеру 800-362-2266 TTY:711.	Russian
ATTENZIONE: Sono disponibili servizi di assistenza linguistica e altri ausili gratuiti. Chiamare il 800-362-2266 TTY:711.	Italian
ATTENTION : Des services d'assistance linguistique et d'autres ressources d'aide vous sont offerts gratuitement. Composez le 800-362-2266 TTY:711.	French
ATANSYON: Gen sèvis pou bay asistans nan lang ak lòt èd ki disponib gratis pou ou. Rele 800-362-2266 TTY:711.	French Creole
אכטונג: שפראך הילף סערוויסעס און אנדערע הילף, זענען אוועילעבל פאר אייך אומזיסט. רופט 800-362-2266 TTY:711	Yiddish
UWAGA: Dostępne są bezpłatne usługi językowe oraz inne formy pomocy. Zadzwoń: 800-362-2266 TTY:711.	Polish
ATENSYON: Available ang mga serbisyong tulong sa wika at iba pang tulong nang libre. Tumawag sa 800-362-2266 TTY:711.	Tagalog
মনোযোগ নামূল্যে ভাষা সহায়তা পরিষেবা এবং অন্যান্য সাহায্য আপনার জন্য উপলব্ধ। 800-362-2266 TTY:711-এ ফোন করুন।	Bengali
VINI RE: Për ju disponohen shërbime asistence gjuhësore dhe ndihma të tjera falas. Telefononi 800-362-2266 TTY:711.	Albanian
ΠΡΟΣΟΧΗ: Υπηρεσίες γλωσσικής βοήθειας και άλλα βοηθήματα είναι στη διάθεσή σας, δωρεάν. Καλέστε στο 800-362-2266 TTY:711.	Greek
توجہ فرمائیں: زبان میں معاونت کی خدمات اور دیگر معاونتیں آپ کے لیے بلا معاوضہ دستیاب ہیں۔ کال کریں 800-362-2266 TTY:711۔	Urdu