Alignment Health Plan

OMB No. 0938-1378
Expires: 7/31/2023

Individual 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 HMO C-SNP or HMO D-SNP 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 HMO C-SNP or HMO D-SNP Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)
- Have a chronic, qualifying condition to be eligible for an HMO C-SNP plan and/or
- Receive both Medicare and medical assistance from a state plan under Medicaid

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:
Alignment Health Plan
P.O. Box 14010
Orange, CA 92863-9936

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

How do I get help with this form?

Call Alignment Health Plan at 888-979-2247. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Effective Date: _____

SECTION 1 – ALL FIELDS ON THIS PAGE ARE REQUIRED (UNLESS MARKED OPTIONAL)

Select the plan you want to join:

ARIZONA

Maricopa, Pima, Santa Cruz

☐ **Alignment Health Heart & Diabetes (HMO C-SNP) 003** $0/month

Optional Buy Up

☐ Enhanced Dental Option $32/month

CALIFORNIA

☐ **Alignment Health Heart & Diabetes (HMO C-SNP) 010**

Alameda, Fresno, Los Angeles, Madera, Marin, Orange, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, Santa Clara, Stanislaus, Ventura $0/month

☐ **Alignment Health ESRD Balance (HMO C-SNP) 033**

Los Angeles, Orange..... $0/month

Optional Buy Up

☐ Enhanced Dental Option $27/month

☐ **Alignment Health CalPlusDuals (HMO D-SNP) 030**

Marin, San Francisco, San Joaquin, San Luis Obispo, Stanislaus, Ventura ..... $0/month Part C
$14.80/month Part D*

FLORIDA

Clay, Sarasota, Duval, Manatee

☐ **Alignment Health Heart & Diabetes (HMO C-SNP) 003** $0/month

Optional Buy Up

☐ Enhanced Dental Option $27/month

☐ **Alignment Health the ONE (HMO D-SNP) 004**..... $15.40/month

NEVADA

Clark, Washoe, Nye, Carson City, Douglas, Storey

☐ **Alignment Health Heart & Diabetes (HMO C-SNP) 004** $0/month

☐ **Alignment Health the ONE (HMO D-SNP) 005**..... $0/month Part C
$14.20/month Part D

☐ **Alignment Health Duals (PPO D-SNP) 001**..... $0/month Part C
$15.30/month Part D

NORTH CAROLINA

Avery, Buncombe, Chatham, Davie, Davidson, Forsyth, Guilford, Henderson, Johnston, Madison, McDowell, Mitchell, Orange, Transylvania, Wake, Wilkes

☐ **Alignment Health Heart & Diabetes (HMO C-SNP) 005** $0/month

☐ **Alignment Health NC Duals (HMO D-SNP) 004**..... $0/month Part C
$19/month Part D

TEXAS

☐ **Alignment Health Heart & Diabetes (HMO C-SNP) 002** $0/month

First name:	Last name:	Middle initial (Optional):
Birth date: (MM/DD/YYYY) (__ __ / __ __ /__ __ __ __)	Sex: ☐ Male ☐ Female	Home Phone Number: ( )
Email address:		Cell Phone Number (Optional): ( )
Permanent Residence street address (Don't enter a PO Box):		

City:	County (Optional):	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):

Street Address: _____ City: _____ State: _____ ZIP Code: _____

Emergency contact:

Relationship:	Phone number: ( )

YOUR MEDICARE INFORMATION:

Medicare Number:	__ __ __ __ - __ __ __ - __ __ __ __

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Alignment Health Plan? ☐ Yes ☐ No

Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage: _____

Please choose the name of a Primary Care Provider (PCP).

Primary Care Provider: _____ Primary Care Provider ID: _____ Medical Group: _____

Do you have a chronic condition that qualifies you for a special needs plan? ☐ Yes ☐ No

Are you eligible or enrolled in a State Medicaid or Medi-Cal program? ☐ Yes ☐ No

If you are enrolled in your State Medicaid Program?

Medicaid number: _____

IMPORTANT: READ AND SIGN BELOW:

- I must keep Hospital (Part A) or Medical (Part B) to stay in Alignment Health Plan.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Alignment Health Plan 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.
- 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.
- I understand that when my Alignment Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Alignment Health Plan. Benefits and services provided by Alignment Health Plan and contained in my Alignment Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Alignment Health Plan 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're the authorized representative, sign above and fill out these fields:

Name:	Address:
Phone number:	Relationship to enrollee:

SECTION 2 – ALL FIELDS ON THIS PAGE ARE OPTIONAL

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.
☐ No, not of Hispanic, Latino/a, or Spanish origin ☐ Yes, Mexican, Mexican American, Chicano/a ☐ Yes, Puerto Rican
☐ Yes, Cuban ☐ Yes, another Hispanic, Latino/a, or Spanish origin ☐ I choose not to answer.

What's your race? Select all that apply.
☐ 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 ☐ White ☐ I choose not to answer.

Select one if you want us to send you information in a language other than English.
☐ English ☐ Spanish ☐ Vietnamese ☐ Chinese ☐ Korean ☐ Other

Select one if you want us to send you information in an accessible format.
☐ Braille ☐ Large print
Please contact Alignment Health Plan at 1-866-634-2247 (TTY 711) if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., 7 days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

Do you work? ☐ Yes ☐ No	Does your spouse work? ☐ Yes ☐ No

The following materials will be sent to you via email unless you prefer to receive a printed copy. Please check below if you prefer to receive a printed version.
☐ Part C Explanation of Benefits (EOB)
☐ Part D Explanation of Benefits (EOB)
☐ Annual Notification of Change (ANOC)

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. **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 plan premium and/or late enrollment payment option:
☐ Get a bill
☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (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 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 Alignment Health Plan the Part D-IRMAA.

Sales Representative (if assisted with Enrollment)
Enrolling Sales Representative's Signature:

_____ NPN#: _____
Print Name: _____ Sales ID#: _____
Phone Number: _____ Date: _____

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 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.

SPECIAL NEEDS PLAN (SNP)
PRE-QUALIFICATION FORM

Alignment Health Plan

TELL US ABOUT YOURSELF (PLEASE PRINT)

Member Name _____ Date _____

Member DOB _____ Member Number/Medicare Beneficiary Identifier (MBI) _____

Member Address _____

City _____ State _____

Zip Code _____ County _____ Member Phone # _____

Member Emergency Contact _____

Member Emergency Contact Phone # _____

Do you consider yourself to be homebound? ☐ Yes ☐ No

PHYSICIAN CURRENTLY TREATING THE APPLICANT FOR THE QUALIFYING DISEASE

Primary Care Physician Currently Treating the Condition(s)

Physician Name _____

Physician Phone # _____

Other Treating Specialists _____

Physician Name _____

Physician Phone # _____

☐ I authorize for AHP to request medical records from my physician(s)

Clinical Qualifying Questions

Alignment Health HMO C-SNP plans.

Diabetes

- Have you been told by a doctor that you have diabetes (too much sugar in the blood or urine)? ☐ Yes ☐ No ☐ Not sure
- Have you ever been prescribed or are you taking insulin or an oral medication that is supposed to lower the sugar in your blood? ☐ Yes ☐ No ☐ Not sure

Cardiovascular Disorders

- Have you ever been told by a doctor that you have coronary artery disease, poor circulation due to hardening of the arteries or poor veins? ☐ Yes ☐ No ☐ Not sure
- Have you ever had a heart attack or been admitted to the hospital for Angina (chest pain)? ☐ Yes ☐ No ☐ Not sure

Chronic Heart Failure

- Have you ever been told by a doctor that you have heart failure (weak heart)? ☐ Yes ☐ No ☐ Not sure
- Have you ever had problems with fluid in your lungs and swelling in your legs in the past, accompanied by shortness of breath, due to a heart problem? ☐ Yes ☐ No ☐ Not sure

PLEASE TURN OVER TO COMPLETE THE FORM ➡

List all current Medications: _____

_____

_____

I acknowledge that by joining one of Alignment Health Plan HMO C-SNP plans, I am enrolling in a plan which offers special programs specifically designed to maintain or improve my health condition. I understand that I am required to make an appointment at an Alignment Healthcare Center to get my special care plan underway. At that time, a health care provider will also verify any prequalifying conditions.

Enrollee Signature _____ Date _____

Agent/Broker Name _____ Date _____

Agent/Broker Signature _____

Appointment scheduled at time of enrollment? ☐ Yes ☐ No

Date _____ Time _____ Location _____