HIGHMARK

MEDICARE D-SNP

2025

Enrollment Application

Highmark Health Options Duals

Apply with this form, online or by phone. If you have any questions, we're here to help!

highmarkhealthoptions.com/duals

1-855-401-8251
(TTY 711)

October 1 – March 31	**8 a.m. to 8 p.m., 7 days a week**
April 1 – September 30	**8 a.m. to 8 p.m., Monday – Friday**

Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield offers HMO plans with a Medicare contract. Enrollment in these plans depends on contract renewal.

Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association and is offering the Highmark Health Options Duals Medicare D-SNP product.

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ENR-468 (9-24)

OMB No. 0938-1378
Expires: 6/30/2026

MODEL 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 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 and 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?

Fill out this form online at **highmarkhealthoptions.com/duals** or mail your completed and signed form to:

Highmark Health Options Duals DE

Attn: Enrollment

PO Box 890032

Camp Hill, PA 17089-0032

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

How do I get help with this form?

Call Highmark Health Options Duals at 1-855-401-8251.
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 espanol: Llame a Highmark Health Options Duals al 1-855-401-8251 (los usuarios de TTY pueden llamar 711) o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en espanol y un representate estara 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.

Section 1 — All fields on this page are required unless marked as optional

Please check which plan you want to enroll in:

☐ **Highmark Health Options Duals (HMO SNP)**
$0 per month

First Name **Last Name** **Middle Initial (optional)**

Birth Date
M M / D D / Y Y Y Y

Sex
☐ M ☐ F

Phone Number
( )

Social Security Number (optional)

Permanent Residence Street Address (Don't enter a PO Box):

City **County** **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 Please provide your Medicare number as shown on your red, white and blue Medicare Health Insurance card.

_ _ _ _ - _ _ _ - _ _ _ _

Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Highmark Health Options Duals?

☐ Yes ☐ No

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

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, Puerto Rican
- ❑ Yes, another Hispanic, Latino/a or Spanish origin
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Cuban
- ❑ **I choose not to answer.**

What's your race? Select all that apply.

- ❑ American Indian or Alaska Native
- ❑ Chinese
- ❑ Japanese
- ❑ Other Asian
- ❑ Vietnamese
- ❑ Asian Indian
- ❑ Filipino
- ❑ Korean
- ❑ Other Pacific Islander
- ❑ White
- ❑ Black or African American
- ❑ Guamanian or Chamorro
- ❑ Native Hawaiian
- ❑ Somoan
- ❑ **I choose not to answer**

What is your gender? Select One.

- ❑ Woman ❑ Man ❑ Non-binary ❑ I use a different term_____
- ❑ **I choose not to answer**

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

- ❑ Lesbian or gay ❑ Straight, that is not gay or lesbian ❑ Bisexual
- ❑ I use a different term_____ ❑ I don't know ❑ **I choose not to answer**

Select one if you want us to send you information in a language other than English.

☐ Spanish ☐ Other Language _____ (write in)

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Please contact Highmark Health Options Duals at 1-855-401-8251 if you need information in an accessible format or language other than what is listed above. TTY users should call 711. Our office hours are:

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

Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If yes, please provide Medicaid number: _____

List your primary care physician (PCP), clinic, or health center:

_____

Address and/or phone number of primary care physician (PCP), clinic, or health center:

_____

☐ I am a current patient of this provider.

Please provide your e-mail and/or phone number if you'd like communications related to health education, reminders,and other information (Optional).

E-mail: _____ Phone number: _____

These emails may include sensitive health information specific to your needs. If you opt in to receive emails and/or text messages, there is a chance that emails and/or texts sent to you could be monitored, intercepted, read, and/or changed by an unauthorized third party before reaching your email inbox, and that it is possible that information intended for you could go to the wrong person or that your electronic accounts could be hacked. By opting in, you understand and accept these risks.

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 Prescription Drug 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 Prescription Drug 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.

New to Medicare or a Change To Your Coverage

- ❑ I am making my annual enrollment election (October 15 - December 7)
- ❑ I am new to Medicare.
- ❑ I recently involuntarily lost my creditable prescription coverage ("creditable" means coverage as good as Medicare's). I lost my drug coverage on _____ (insert date).
- ❑ I am leaving or have left employer or union coverage on _____ (insert date).
- ❑ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

Recent Change in Residence

- ❑ I recently moved or plan to move outside of the service area for my current plan, or I recently moved or plan to move and this plan is a new option for me _____ (insert move date).
- ❑ I recently returned to the U.S. after living permanently outside of the U.S. I returned to the U.S. on _____ (insert date).
- ❑ I am moving into, live in, or recently moved out of a Long-Term Care facility (for example, a nursing home).

  I moved/ will move into/ out of the facility on _____ (insert date).
- ❑ I recently obtained lawful presence status in the U.S. I got this status on _____ (insert date).
- ❑ I recently was released from incarceration. I was released on _____ (insert date).

Attestation of Eligibility for an Enrollment Period

Change in Income or Special Needs/Plan Qualifications

- ❑ 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 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 belong to a pharmacy assistance program provided by my state.
- ❑ I recently left a PACE plan (Program of All-Inclusive Care for the Elderly) 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 am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ❑ 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 recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, lost Medicaid) on _____ (insert date).
- ❑ This is my first time for Part B Entitlement.
- ❑ In the last 12 months, I left a Medigap policy to join a Medicare Advantage Plan* for the first time (*Medicare Advantage plan with prescription drug coverage).
- ❑ I have been on Medicare but just turned 65 or will be turning 65 in the next three months.
- ❑ My current plan was placed into Receivership by CMS due to financial difficulties.
- ❑ I am within the 4th to 7th month of my initial election period.

Other Reason

- ❑ I am in a plan that is identified as a consistent poor performer.
- ❑ 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.
- ❑ I am enrolling in a 5-Star Medicare plan.
- ❑ None of the above apply.

IMPORTANT: Read and Sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Highmark Health Options Duals Medicare Advantage plan.
- By joining this Medicare Advantage Plan, I acknowledge that Highmark Health Options Duals 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 above).
- 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).
- 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 when my Highmark Health Options Duals coverage begins, I must get all of my medical and prescription drug benefits from Highmark Health Options Duals. Benefits and services provided by Highmark Health Options Duals and contained in my Highmark Health Options Duals "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Highmark Health Options Duals 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, you must sign above and provide the following information:

Name

Address

Phone Number ( )

Relationship to Enrollee

Agent, Broker, or Third Party Use Only

Broker/Agent/Third Party Name: _____

NPN (If applicable): _____

Relationship to Enrollee: _____

Effective Date of Coverage: _____

Date Received: _____

Internal Office Use Only

Plan ID#: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Highmark Health Options Duals complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation. Highmark Health Options Duals does not exclude people or treat them differently because of their race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation.

Highmark Health Options Duals provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in a different way, including large print, audio, and Braille.

Highmark Health Options Duals provides free language services to people whose primary language is not English, such as:

- Qualified interpreters.
- Information written in other languages.

If you need these services, contact Highmark Health Options Duals Member Services at 1-855-401-8251 (TTY: 711 or 1-800-232-5460), Monday – Friday, 8 a.m. – 8 p.m.

If you believe that Highmark Health Options Duals has failed to provide these services or discriminated against you in another way because of your race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation, you can file a complaint with Highmark Health Options Duals or the Delaware Division of Human and Civil Rights by mail, phone, or web form.

Highmark Health Options Duals
Attn: Appeals and Grievances
P.O. Box 890416
Camp Hill, PA 17089-0416
1-855-401-8251

Division of Human and Civil Rights
861 Silver Lake Blvd., Suite 145
Dover, DE 19904
302-739-4567
hho.fyi/ea-intake

If you need help filing a complaint, Highmark Health Options Duals and the Division of Human and Civil Rights are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights online at OCRPortal.hhs.gov, and by mail, phone, or email:

U.S. Department of Health and Human Services
200 Independence Avenue SW
HHH Building Room 509F
Washington, DC 20201
1-800-368-1019 (TTY: 1-800-537-7697)
OCRMail@hhs.gov

A printable version of the complaint form is available at hho.fyi/complaint-form.

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-401-8251 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-401-8251. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-855-401-8251。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-855-401-8251。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-401-8251. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-401-8251. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-855-401-8251 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-401-8251. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-401-8251번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-855-401-8251. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-855-401-8251. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-855-401-8251 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-855-401-8251. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-401-8251. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-855-401-8251. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-855-401-8251. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-855-401-8251 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。