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

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 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:

Centers Plan for Healthy Living
75 Vanderbilt Avenue
Staten Island, NY 10304

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

How do I get help with this form?

Call Centers Plan for Healthy Living at 1-877-940-9330. 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 Centers Plan for Healthy Living al 1-877-940-9330/TTY 711 o, a Medicare gratis al 1-800-633-4227 y oprima el 8 en español y un representante estará disponible para asistirle. Los usuarios de TTY pueden llamar 1-877-486-2048.

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 optional)

Select the plan you want to join:

☐ Centers Plan for Medicare Advantage Care (HMO)	$0.00 per month
☐ Centers Plan for Dual Coverage Care (HMO D-SNP)	$72.30 per month
☐ Centers Plan for Nursing Home Care (HMO I-SNP)	$72.30 per month

FIRST name: LAST name: [Optional: Middle Initial]:

Birth date: (MM/DD/YYYY) (____/____/_____)	Sex: ☐Male ☐Female	Phone number: ( )

Permanent Residence street address (Don't enter a PO Box. Note For individuals experiencing homelessness, a PO Box may be considered your permanent residence address):

City:	[Optional: 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: ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Centers Plan for Healthy Living? ☐Yes ☐No

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

_____ _____ _____

For People with Medicare and Medicaid ONLY: Are you enrolled in your State Medicaid program?
☐Yes ☐No

If yes, please provide your Medicaid number: ___ ___ ___ ___ ___ ___ ___ ___

For I-SNP ONLY: Are you a resident in a long-term care facility, such as a nursing home?
☐Yes ☐No

If yes, please provide the following information:

Name of the Institution: _____

Address: _____

Telephone number: _____

Admission date: _____

IMPORTANT: Read and sign below:	
• I must keep both Hospital (Part A) and Medical (Part B) to stay in Centers Plan for Healthy Living. • By joining this Medicare Advantage, I acknowledge that Centers Plan for Healthy Living 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 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). • 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 Centers Plan for Healthy Living coverage begins, I must get all of my medical and prescription drug benefits from Centers Plan for Healthy Living. Benefits and services provided by Centers Plan for Healthy Living and contained in my Centers Plan for Healthy Living "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Centers Plan for Healthy Living 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:	**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, 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

Asian:

- ☐Asian Indian
- ☐Chinese
- ☐Filipino
- ☐Japanese
- ☐Korean
- ☐Vietnamese
- ☐Other Asian

- ☐Black or African American

Native Hawaiian and Pacific Islander:

- ☐Guamanian or Chamorro
- ☐Native Hawaiian
- ☐Samoan
- ☐Other Pacific Islander

- ☐White
- ☐**I choose not to answer**

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

☐Spanish ☐Chinese ☐Other: _____

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

☐Braille ☐Large Print ☐Audio CD ☐Data CD

Please contact Centers Plan for Healthy Living at 1-877-940-9330 if you need information in an accessible format other than what's listed above. Our office hours are 8 am - 8 pm, 7 days a week. TTY users can call 711.

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

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

Name: Address: Phone number:

_____ _____ _____

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

- ☐ Evidence of Coverage
- ☐ Pharmacy Directory
- ☐ Provider Directory
- ☐ Comprehensive Formulary (Drug List)

Email address: _____

Please contact Centers Plan for Healthy Living at 1-877-940-9330 if you want to get one of these materials by email. Our office hours are 8 am-8 pm, 7 days a week. TTY users can call 711.

Emergency Contact:

Name:	Phone Number:	Relationship to You:
_____	_____	_____

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.**

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 Centers Plan for Healthy Living the Part D-IRMAA.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Get a bill

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

☐SSA ☐RRB

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): _____

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.

75 Vanderbilt Ave Staten Island NY 10304 1-844-CPHL-CARES www.centersplan.com

Attestation of Eligibility for an Enrollment Period

Name: _____

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 (EPIC) since (insert date) _____ and have not used this election to enroll in another MAPD/PDP this year.

- ☐ I recently enrolled in a pharmacy assistance program provided by my state (EPIC) and my coverage begins on (insert date) _____.

- ☐ I recently disenrolled from a pharmacy assistance program provided by my state (EPIC) and my last day of coverage was (insert date) _____.

- ☐ 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.
    - FEMA declared situation: _____
    - Attempted SEP: _____

If none of these statements applies to you or you're not sure, please contact Centers Plan for Healthy Living at 1-(877)-940-9330 (TTY Users should call 711) to see if you are eligible to enroll. We are open Monday-Sunday, 8 am to 8 pm.

By checking any of the following boxes above, and signing this form you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period.

Signature: _____ Date: _____