

Individual Enrollment Request Form

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
- Be a resident in a Georgia Health Advantage contracted nursing home facility

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 your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Georgia Health Advantage
201 Jordan Rd, Suite 200
Franklin, TN 37067

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

How do I get help with this form?

Call Georgia Health Advantage at 1-844-917-0645. TTY users can call 1-833-312-0046, or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En Español: Llame a Georgia Health Advantage al 1-844-917-0645/TTY 1-833-312-0046 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

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 0938-1378. 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.*

Select the plan you want to join:

- Georgia Health Advantage (HMO I-SNP) [H8093-001] – \$44.20 per month
- Georgia Health Advantage Choice (HMO I-SNP) [H8093-002] – \$44.20 per month

First name: _____ Middle initial: _____ Last name: _____

Birth date: (MM/DD/YYYY) (____ / ____ / _____) Sex: ___ Male ___ Female

Phone number: (____) _____ - _____

Permanent residence street address (please do not enter a P.O. box)

Street: _____

City: _____ State: _____ Zip code: _____ County: _____

Mailing address, *if different from your permanent address* (P.O. box allowed)

Street: _____

City: _____ State: _____ Zip code: _____ County: _____

Your Medicare information

Medicare number: _____ - _____ - _____

Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Georgia Health Advantage?

- Yes
- No

Name of other coverage: _____

Member number for this coverage: _____ Group number for this coverage: _____

Do you reside at home or in an assisted living facility? Yes No

If *yes*, has the state that you reside in certified that you need the type of care that is usually provided in a nursing

home? Yes No

Are you a resident of or expect to be a resident of a long-term care facility or an assisted living facility in the Georgia Health Advantage network for more than 90 days? Yes No

If *yes*, please provide the following information:

Name of facility: _____

Facility address: _____

City: _____ State: _____ Zip code: _____ County: _____

IMPORTANT: Read and sign below

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

Name: _____

Street address: _____

City: _____ State: _____ Zip code: _____ County: _____

Phone number: (_____) _____ - _____ Relationship to enrollee: _____

Office use only

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID#: _____ Effective date of coverage: _____ / _____ / _____

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

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
 Vietnamese White
 I choose not to answer.

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

Please contact Georgia Health Advantage at 1-844-917-0645 if you need information in an accessible format other than a large print format.

Our office hours are:

October 1 – March 31
8:00 am – 8:00 pm, seven days a week

April 1 – September 30
8:00 am – 8:00 pm, Monday – Friday

TTY users can call 1-833-312-0046.

Do you work? Yes No

Does your spouse work? Yes No

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

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 Georgia Health Advantage the Part D-IRMAA.

Please select a premium payment option:

- Get a bill each month
 Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: Social Security RRB

(The Social Security 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 a premium payment option is not selected above, the default action will be direct bill.

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 and 1860D-1 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.