OMB No. 0938-1378
Expires: 07/31/2023

PROVIDENCE
Medicare Advantage Plans
A division of Providence Health Assurance

2022 MEDICARE ADVANTAGE 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

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?

Submit your completed and signed form using one of the three options below:
Providence Medicare Advantage Plans
P.O. Box 5548
Portland, OR 97228-5548

Scan and fax pages to:
503-574-8653

Scan and email pages to:
provMedicare@providence.org

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

How do I get help with this form?

Call Providence Medicare Advantage Plans at **503-574-6508** or **1-855-234-2495**. 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 Providence Medicare Advantage Plans al **503-574-6508** or **1-855-234-2495/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.

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

☐ Providence Medicare Focus Medical (HMO) - $128 per month

☐ Providence Medicare Select Medical (HMO-POS) - $51 per month

To enroll in an Optional Supplemental Dental Plan*, please select the plan you want to join:

☐ **Basic:** $32.50 per month.

☐ **Enhanced:** $45.10 per month.

*I understand enrollment in the plan listed above is optional. I also understand that I must maintain my coverage in Providence Medicare Advantage Plans in order to be enrolled in the optional supplemental dental plan selected. Additionally, I understand that I must pay the optional supplemental dental plan premium in order to maintain my coverage. I will read the optional benefit plan information when I receive it and learn my responsibilities as a member and what services are covered by the plan.

FIRST name _____ LAST name _____ Middle Initial (Optional) _____

__ __/__ __/__ __ __ __
Birth date (MM/DD/YYYY)

SEX: ☐Male ☐Female

Phone number _____

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 _____

Your Medicare information:

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

__ __/__ __/__ __ __ __
Hospital (Part A) Effective Date (Optional)

__ __/__ __/__ __ __ __
Medical (Part B) Effective Date (Optional)

Answer these important questions:

Will you have other coverage in addition to Providence Medicare Advantage Plans? ☐Yes ☐No

Some individuals may have other coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

If "yes," please list your other coverage and your identification (ID) number for this coverage.

_____
Name of other coverage

_____ _____
ID number for this coverage Group number for this coverage

Check all that apply: ☐Medical ☐Vision ☐Dental ☐Prescription

IMPORTANT: Read and sign below:

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

_____ _____

Name Address

_____ _____

Phone number Relationship to enrollee

AGENT USE ONLY

_____ ___ ___/___ ___/___ ___

AGENT NAME DATE

_____ ___ ___/___ ___/___ ___

NPN # REQUESTED DATE OF 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.

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

_____

If you do not provide a PCP, one will be assigned.

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

☐ Braille ☐ Large print ☐ Audio CD

Please contact Providence Medicare Advantage Plans at 1-800-603-2340 or 503-574-8000 if you need information in an accessible format other than what's listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. (Pacific Time). TTY users can call 711.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

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 premium payment option:

☐ Get a monthly bill – Once you receive your first bill, you can choose a different payment option:

+ You can pay by credit/debit card or checking/savings account: One-time or recurring payments can be made via your myProvidence account at myProvidence.com or through the Providence website at providence.org/premiumpay.
+ You can pay by phone: Self Service is available 24 hours a day, 7 days a week, at 1-888-821-2097, TTY: 711.

☐ 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/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. You may receive an invoice for the first few months before the withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a letter and paper bill for your monthly premiums.)

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. However, failure to respond may affect enrollment in the plan.

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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 leaving employer or union coverage 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 am enrolling during the Annual Enrollment Period (October 15-December 7) or Special Enrollment Period.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) (January 1-March 31).
- ☐ 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 belong to a pharmacy assistance program provided by my state.
- ☐ I recently left a PACE program 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 the facility on (insert date): ___ ___/___ ___/___ ___

  I moved/will move out of the facility 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):___ ___/___ ___/___ ___
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan (insert date): ___ ___/___ ___/___ ___

☐ 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.

Name of disaster impacted by:

_____

Eligibility Period that was missed due to the disaster: (for example, the initial enrollment period, annual enrollment period, open enrollment period, or a special enrollment period).

_____

☐ I was impacted by a significant network change with my current plan and was notified on (insert date): ___ ___/___ ___/___ ___

If none of these statements applies to you or you're not sure, please contact Providence Medicare Advantage Plans at 1-800-603-2340 or 503-574-8000 (TTY users should call 711) to see if you are eligible to enroll. We are open seven days a week, 8 a.m. to 8 p.m. (Pacific Time).

Race/Ethnicity Questionnaire

The following questions will help us to better serve all communities. These questions are optional.

Which of the following describes your racial or ethnic identity?

Please check all that apply.

Hispanic or Latino/a/x

- ☐ Hispanic or Latino/a/x Central American
- ☐ Hispanic or Latino/a/x Mexican
- ☐ Hispanic or Latino/a/x South American
- ☐ Other Hispanic or Latino/a/x

Native Hawaiian or Pacific Islander

- ☐ Guamanian or Chamorro
- ☐ Marshallese
- ☐ Communities of the Micronesian Region
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Tongan
- ☐ Other Pacific Islander

Other

- ☐ Other
- ☐ Don't know
- ☐ Don't want to answer

American Indian or Alaska Native

- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

White

- ☐ Caucasian/White (no national affiliation)
- ☐ Eastern European
- ☐ Western European
- ☐ Other White (African, Australian, New Zealand descent)
- ☐ Slavic

Middle Eastern or North African

- ☐ Middle Eastern
- ☐ North African

Black or African American

- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Afro-Latinx/Bi-racial/Other
- ☐ Other Black

Asian

- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

If you checked more than one category above, is there one you think of as your primary racial or ethnic identity?

- ☐ **Yes** (please specify): _____
- ☐ **No:** I do not have just one primary racial or ethnic identity.
- ☐ **No:** I identify as Biracial or Multiracial.
- ☐ **N/A:** I only checked one category above.
- ☐ **N/A:** I don't know.
- ☐ **N/A:** I don't want to answer.

What is your preferred spoken language?

- ☐ English
- ☐ Spanish
- ☐ Chinese - Other
- ☐ Mandarin
- ☐ Cantonese
- ☐ Vietnamese
- ☐ Russian
- ☐ German
- ☐ French
- ☐ Tagalog
- ☐ Japanese
- ☐ Korean
- ☐ Arabic
- ☐ Decline/Unknown
- ☐ Other