OMB No. 0938-1378
Expires: 07/31/2024

Providence
Medicare Advantage Plans

2024 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.

What happens next?

Submit your completed and signed form using one of the three options below. Once they process your request to join, they'll contact you.

01 By mail:
Providence Medicare Advantage Plans
P.O. Box 5548
Portland, OR 97228-5548

02 Scan and fax pages to:
503-574-8653

03 Scan and email pages to:
provMedicare@providence.org

How do I get help with this form?

- Call Providence Medicare Advantage Plans at **503-574-6508** or **1-855-234-2495 (TTY: 711)**.
- Or, call Medicare at **1-800-MEDICARE** (**1-800-633-4227**). TTY: **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.

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.

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.

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

Select the plan you want to join:

- ☐ Providence Medicare Bridge + Rx (HMO-POS) - $29 per month
- ☐ Providence Medicare Choice + Rx (HMO-POS) - $71 per month
- ☐ Providence Medicare Extra + Rx (HMO) - $155 per month
- ☐ Providence Medicare Timber + Rx (HMO) - $0 per month

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

- ☐ **Basic:** $33 per month
- ☐ **Enhanced:** $45 per month
- ☐ Do not want Optional Supplemental Dental Plan

*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 _____

Email Address

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.
- 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).
- 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 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.

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.**

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.**

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 Providence Medicare Advantage Plans the Part D-IRMAA.

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 **1-844-791-1468, 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 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)
- ☐ I am enrolling during a Special Enrollment Period (insert special enrollment being used) _____
- ☐ 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 impacted by a significant network change with my current plan and was notified on (insert date): ___ ___ /___ ___/___ ___
- ☐ I recently received notice of a Medicare entitlement determination for a retroactive effective date. (Please attach a copy of your entitlement notice.) I was notified 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).

  _____

> 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).

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