MoreCare Medicare Advantage Plans

Enrollment Request Form

MoreCare®
A Medical Home Network Affiliate

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: **Enrollment@morecareil.com** or

MoreCare Enrollment
PO Box 64540
Chicago, IL
60664

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

How do I get help with this form?
Call MoreCare at 844-480-8528. 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 MoreCare al 844-480-8528 (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.

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

Select the Plan You Want to Join:

Plan Name	Plan Type and ID
☐ MoreCare For You (HMO) – $0 per month	Medicare Advantage Prescription Drug Plan (001)
☐ MoreCare + (HMO SNP) – $0 per month	Chronic Condition Special Needs Plan (002)
☐ MoreCare Home (HMO SNP) – $0 per month	Institutional Special Needs Plan (003)
☐ MoreCare At Home (HMO SNP) – $0 per month	Institutional (Equivalent) Special Needs Plan (004)

Last Name:	Middle Initial (optional):
First Name:	
Sex ☐ M ☐ F	Preferred Pronouns (optional):
Birth Date: (MM/DD/YYYY)	Email (optional):
Phone Number: ☐ Home ☐ Mobile	Alt. Phone: ☐ Home ☐ Mobile

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

Street Address:

City:	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 MoreCare? ☐ Yes ☐ No

Name of Other Coverage:

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

SNP Plan Pre-Enrollment Qualification Assessment Tool

If you are enrolling in one of our Special Needs Plans, please complete our Pre-Enrollment Qualification Assessment Tool.

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

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.

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.

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

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

☐ Braille ☐ Large Print ☐ Audio CD

Please contact MoreCare at **844-480-8528** if you need information in an accessible format other than what's listed above. Our office hours are 8am-8pm CST, 7 days a week. (Monday-Friday, April 1 – September 30). TTY users can call 711.

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

List the name of your Primary Care Provider (PCP):

PCP Location or Clinic Name:

PCP ID/NPI # (if available):

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 Institution

Address of Institution (number and street)

Phone Number

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

If yes, please provide your Medicaid Number

Do you receive Extra Help paying for Medicare prescription drug coverage? ☐ Yes ☐ No

Several important Plan documents; such as, our Evidence of Coverage, Provider Directory, Pharmacy Directory, and Formulary (drug list), are available on our website or through the member portal. Additional information on how to access electronic copies will be included in your welcome kit.

If you would like to receive paper copies, please contact Member Services at 844-480-8528 (TTY: 711).

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

☐ These Plan documents: Evidence of Coverage and Summary of Benefits

☐ Member updates, such as our Newsletter

Please make sure you provided your email address on Page 1.

To ensure you stay up to date on plan activities and your care, *MoreCare* may communicate with you via text message if you provided a mobile phone number. Standard messaging rates apply. You will always have the option to opt-out.

If you do not want to receive text messages from *MoreCare*, please check the box below:

☐ No, I do not want to receive text messages from *MoreCare*.

Paying your plan premiums

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), you can pay 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 *MoreCare* the Part D-IRMAA.

Office Use Only

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

Agent ID #: Effective Date of Coverage:

Event ID: Confirmation Number:

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 enrolling during the annual enrollment period (October 15 – December 7)
- ☐ 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 here) .
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date here) .
- ☐ I recently obtained lawful presence status in the United States. I got status on (insert date here) .
- ☐ 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 (insert date here) .
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date here) .
- ☐ I am leaving employer or union coverage on (insert date here) .
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ 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 here) .
- ☐ I want to join a Special Needs Plan that tailors its benefits to my chronic condition.
- ☐ 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 because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact MoreCare at **844-480-8528 (TTY: 711)** to see if you are eligible to enroll. Our office hours are Monday – Friday, 8am to 8pm CST from April 1 – September 30. (7 days a week, October 1 – March 31).