OMB No. 0938-1378
Expires: 7/31/2024

Individual Enrollment Request Form To Enroll In A Medicare Advantage Plan (Part C)

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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.
- Any month in which and individual meets the eligibility requirements for the ESRD C-SNP.

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.

Individual Enrollment Request Form To Enroll In A Medicare Advantage Plan (Part C) Continued

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What happens next?

Send your completed and signed form to:
Champion Health Plan
PO Box 15337
Long Beach, CA 90815-9995

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

How do I get help with this form?

Call Champion Health Plan at 1-800-885-8000. 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 Champion Health Plan al 1-800-885-8000. 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.

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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.

CHAMPION HEALTH PLAN

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

SELECT THE PLAN YOU WANT TO JOIN:

Champion Advantage (HMO C-SNP) 001

☐ **$0 per month**

Champion Select (HMO C-SNP) 003

☐ **$41 per month**

Champion Connect (HMO C-SNP) 002

☐ **$41 per month**

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FIRST Name | **LAST Name** | **M.I. (Optional)**

Birth Date (MM/DD/YYYY) / / **Sex** ☐ **Male** ☐ **Female** **Phone Number**

Permanent Residence Street Address (Don't enter PO Box) | **County (Optional)**

City | **State** | **Zip Code**

Mailing Address if different from your Permanent Address (PO Box Allowed)

Street Address | **City** | **State** | **Zip Code**

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Your Medicare Information

Medicare Number: __ __ __ __ – __ __ __ – __ __ __ __

Answer these important questions:

1) Will you have other prescription drug coverage (like VA, TRICARE) in addition to Champion Health Plan? ☐ Yes ☐ No

Name Of Other Coverage

Member Number For This Coverage

Group Number For This Coverage

Enrollment in any of the plans listed above requires that you have certain chronic conditions.

Do you require Dialysis services? ☐ Yes ☐ No

Dialysis Center Name

Dialysis Center Address

Phone Number

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IMPORTANT: Read and sign below

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

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Enrollee Signature | **Today's Date**

If you are the authorized representative, you must sign above and provide the following information:

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 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 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 Champion Health Plan at 1-800-885-8000 if you need information in an accessible format other than what's listed above. Our office hours are 8 am to 8 pm, 7 days a week from October 1 - March 31 and 8 am to 8 pm, Monday through Friday from April 1 - September 30. TTY users can call 711.

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

List your Primary Care Physician (PCP)

Primary Treating Physician (Nephrologist)

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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.

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

☐ Evidence of Coverage (EOC) ☐ Provider/Pharmacy Directory ☐ Formulary

Email address: _____

_____

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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 or Electronic Funds Transfer (EFT) or credit card 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. DON'T pay Champion Health Plan the Part D-IRMAA.

Office Use Only:

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

Agent NPN:_____

Plan ID#:_____Effective Date of Coverage:_____

AEP:_____ ICEP:_____ SEP (type):_____ Agent received date:_____

Licensed Sales Agent Signature (required):_____

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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.