Enrollment Form

ProCare ADVANTAGE

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:
ProCare Advantage
PO Box 5849
Glen Allen, VA 23058-5850

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

How do I get help with this form?
Call ProCare Advantage at 1-844-206-3719 (TTY 711).

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a ProCare Advantage al 1-844-206-3719 (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.

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.

SECTION 1: To enroll, all fields in this section are required (unless marked optional)

Please check which plan you want to enroll in:

☐ ProCare Advantage (HMO I-SNP) - $25.10 per month

If you get Extra Help from Medicare, your monthly plan premium will be lower than what it would be if you didn't get Extra Help from Medicare. Depending on your level of Extra Help, your premium may be anywhere between $0 and $25.10. If you are full-dual eligible, with Extra Help, **your premium would be $0.**

Applicant Information: ☐ Male ☐ Female

☐ Mr. ☐ Mrs. ☐ Ms. Birth Date (MM/DD/YYYY): (_____/_____/_____)

First Name _____ Last Name _____ M.I. ___

Medicare Number (MBI)_____

1. Will you have other prescription drug coverage in addition to ProCare Advantage? ☐ Yes ☐ No

   IF YES, please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other drug coverage _____

   ID for this coverage _____

   Group # for this coverage _____

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

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SECTION 1 (continued): To enroll, all fields in this section are required (unless marked optional)

2. Are you a resident of or expect to be a resident of a long-term care facility (LTC) or an assisted living facility (ALF) in ProCare Advantage network for more than 90 days?
   ☐ Yes ☐ No

   IF YES, please fill out the facility information below:

   Name of Facility _____

   Street Address _____

   City _____ State _____ Zip _____

   Phone Number of Facility _____

IMPORTANT: Read and sign below

I must keep both Hospital (Part A) and Medical (Part B) to stay in ProCare Advantage. By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that ProCare 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 ProCare Advantage coverage begins, I must get all of my medical and prescription drug benefits from ProCare Advantage. Benefits and services provided by ProCare Advantage and contained in my ProCare Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor ProCare 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 of applicant or the responsible party X	Today's Date

SECTION 1 (continued): To enroll, all fields in this section are required (unless marked optional)

Applicant Contact Information:

Permanent Residence Address (P.O. Box not allowed)

Street _____

City _____ State _____ Zip _____

Phone (_____) _____ Email* (optional) _____

Mailing Address, if different from permanent address

Attn Name _____

Street _____

City _____ State _____ Zip _____

Responsible Party Contact Information (as applicable):
If you're the authorized representative, you must sign previous page and fill out these fields:

First Name _____ Last Name _____

Relationship to Enrollee _____

Phone ☐ Cell** ☐ Home (_____) _____

Email* (optional)_____

* *By providing your email address, you are opting in to receive electronic communication, when available. If you'd like to opt out of electronic communications, check this box:* ☐ *Opt out*

** *By providing your cell phone number, you are opting in to receive plan communications via SMS/text message. If you do not wish to receive any plan communications or updates via text message, please opt out:* ☐ *Opt out*

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SECTION 2: All fields are optional. Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

1. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

   IF YES, what is your Medicaid number? _____

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

3. Please choose your in-network Primary Care Physician (PCP):

   Physician Name: _____

   Is this your current physician? ☐ Yes ☐ No

4. Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an *accessible* format:

   ☐ Spanish
   ☐ Audio File
   ☐ Large Print
   ☐ Braille

Please contact ProCare Advantage at 1-844-206-3719 (TTY 711) if you need information in an accessible format or language other than what is listed above. Our office hours are 8:00 am to 8:00 pm local time. TTY users can call (TTY 711).

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SECTION 2 (continued): All fields are optional. Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Paying Your Plan Premium

For plans with a premium, 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.**

- ☐ Yes, I'd like my premium to be taken out of my Social Security
- ☐ Yes, I'd like my premium to be taken out of my Railroad Retirement Board (RRB)
- ☐ No, none of the above. I would like a direct bill.

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 ProCare Advantage the Part D-IRMAA.

PRIVACY ACT STATEMENT The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

OFFICE USE ONLY. Please DO NOT complete unless authorized.

Agent First and Last Name _____

Plan ID _____

Application received date _____ Coverage effective date _____

Select the enrollment period:

- ☐ IEP/ICEP
- ☐ AEP
- ☐ OEPI
- ☐ SEP (type) _____
- ☐ Not eligible

Signature _____ Date _____