CoxHealth Medicare Advantage (HMO)

Expires: 07/31/2024

CoxHealth
MedicareAdvantage
by Cox HealthPlans

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

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:

CoxHealth Medicare Advantage
P.O. Box 5750
Springfield, MO 65801-5750

Or fax to: (417) 269-4667

You can also enroll online at:
coxhealthmedicareadvantage.com

Once we process your request to join, we will contact you.

How do I get help with this form?

Call CoxHealth Medicare Advantage at **1-855-752-3795.** 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 **CoxHealth Medicare Advantage** al **1-855-752-3795/711** o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

CoxHealth Medicare Advantage

Individual Enrollment Request Form-2023

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Section 1 - All fields below are required (unless marked optional).

CoxHealth Medicare Advantage (HMO) $0 per month

Last name	First name	MI

Birthdate (MM/DD/YYYY)	Sex ❑ M ❑ F	Email (Optional)

Phone number Is this a mobile number? ❑ Yes ❑ No	Alternate phone number Is this a mobile number? ❑ Yes ❑ No

Permanent residence street address (P.O. Box is not allowed.)

City	State	ZIP code	County

Mailing address (only if different from your permanent residence address; P.O. Box allowed)

City	State	ZIP code	County

Your Medicare information

Medicare Number: ____ ____ ____ ____ - ____ ____ ____ - ____ ____ ____ ____

Please locate the 11-digit alpha-numeric number on your Medicare Card. Example: 1HG7-DE5-WB72

Effective Date: HOSPITAL (Part A)	MEDICAL (Part B)

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to CoxHealth Medicare Advantage?

❑ Yes ❑ No

Name of other coverage:	Member number for this coverage:	Group number for this coverage:

Please choose the name of a Primary Care Physician (PCP).
PCP ID # *(as shown in the printed or online Provider Directory)*

PCP First Name	PCP Last Name

PCP address

City	State	ZIP code

Section 2 - All fields in this section are optional

Answering these questions is your choice.
You can't be denied coverage because you don't fill them out.

Do you or your spouse work? ❑ Yes ❑ No

Paying your plan premium (optional)

You can pay your monthly plan premium, if you have one, (including any late enrollment penalty that you currently have or may owe), by mail or electronic funds transfer (EFT) each month. **You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (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 RRB). DON'T pay Cox HealthPlans the Part D-IRMAA.

Please complete the information below only if you are paying your monthly plan premium, including any late enrollment penalty, by EFT:

Account Type

❑ **Checking** - Enclose a VOIDED check or provide the following information:

❑ **Savings**

Account holder name	Bank name

Bank routing number *(This is the first 9 digits printed on the lower left corner of your check.)*

___ ___ ___ ___ ___ ___ ___ ___ ___

Bank account number

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

- If your enrollment form is approved by CMS, subsequent premium and late enrollment penalty payments will be debited on the 1st of each month.
- The Authorization Agreement will remain in effect until we receive written notification stating your desire to cancel the agreement or the policy terms.
- A monthly statement disclosing your account debit amount will be forwarded to your address.
- All debits will be made on the 1st of each month. If your account has insufficient funds, another attempt will be made to withdraw money from the account.
- Any account changes must be made as soon as possible as it may take up to 10 business days to update account information.
- I hereby authorize Cox Health Systems HMO, Inc. ("Cox") to initiate debit entries, and the Financial Institution named above to debit, my Checking/Savings account in the amount of my monthly premium and late enrollment penalty on the 1st of each month, which shall be applied by Cox for the payment of my health insurance premium and late enrollment penalty. I acknowledge and agree that the timely payment is my sole responsibility.
- This authorization to debit my account will remain in full force and effect until Cox and the above-named Financial Institution receive written notice of termination from me, which is effective ten (10) days after receipt or first date on which Cox and the Financial Institution have a reasonable opportunity to act on it, whichever is later.

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
- ❑ **I choose not to answer.**
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Cuban

What's your race? Select all that apply.

- ❑ American Indian or Alaska Native
- ❑ Black or African American
- ❑ Filipino
- ❑ Japanese
- ❑ Native Hawaiian
- ❑ Other Pacific Islander
- ❑ Vietnamese
- ❑ **I choose not to answer.**
- ❑ Asian Indian
- ❑ Chinese
- ❑ Guamanian or Chamorro
- ❑ Korean
- ❑ Other Asian
- ❑ Samoan
- ❑ White

Section 3 - A Selection is Required

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage (MA) plan only during the Annual Enrollment Period (AEP) between October 15 and December 7 of each year or during the Open Enrollment Period (OEP) between January 1 to March 31. Beneficiaries enrolled in a MA-PD plan may use the OEP to switch to another MA-PD plan; a MA-only plan; or Original Medicare with/without a PDP. Additionally, there are exceptions - i.e., Initial Enrollment Period (IEP/ICEP) and Special Enrollment Periods (SEPs) — that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements carefully and check all of the boxes where there is a statement that 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.

NOTE: At least one option below needs to be selected.

- ❑ I am enrolling during the Annual Open Enrollment Period from October 15 to 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 my 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 was recently 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 the level of Medicaid assistance, or lost Medicaid) on (insert date)_____.

❑ I recently had a change in my Extra Help paying for my 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 Program of All-inclusive Care for the Elderly (PACE®) program 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) _____.

❑ I am leaving employer or union coverage. Employer/Union coverage started on (insert date) _____ and coverage ends on (insert date) _____.

❑ 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) _____.

❑ 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.

*If none of these statements apply to you or you're not sure, please contact CoxHealth Medicare Advantage at 1-855-752-3795 (TTY users should call 711) to see if you are eligible to enroll. Our office hours are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

Section 4 - IMPORTANT: Please read and sign below

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

Applicant signature	Today's date

Authorized Representative Information Only
All fields within this section must be completed if the application has been signed by an Authorized Representative and not the Applicant.

First Name	Last Name	
Address		
City	State	Zip code
Phone Number	Relationship to Enrollee	

Please check one of the boxes below if you would prefer us to send you information in another language or in an accessible format:

❑ Spanish ❑ Voice-Enabled (Audio) PDF ❑ Large Print

Please contact CoxHealth Medicare Advantage at 1-855-752-3795 if you need information in an accessible format or language other than what's listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. TTY users should call 711.

Applicant: Please do not complete the following sections.
Agent/Broker: Please fill in ALL fields.

Print First Name	Print Last Name

I helped the applicant fill out this application. ❑ Yes ❑ No

Scope of Appointment (SOA)
Appointment type:
❑ Face-to-face ❑ Telephone ❑ Webcam

How was the scope of appointment (SOA) collected?
❑ Paper ❑ Electronic ❑ Recorded call (voice recording ID)

Phone

Email

Signature	Application received date

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.

Send your completed and signed form to:

CoxHealth Medicare Advantage
P.O. Box 5750
Springfield, MO 65801-5750

Or fax to: (417) 269-4667