COMMUNITY FIRST
HEALTH PLANS

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN THE COMMUNITY FIRST MEDICARE ADVANTAGE PLAN

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Who can use this form?

People with Medicare who want to join the Community First Medicare Advantage Plan can use this form.

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 the Community First Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance), and
- 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 are 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?

You will need:

- 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 cannot be denied coverage because you do not fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must receive 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:

Community First Health Plans
Medicare Enrollment & Member Services Dept.
12238 Silicon Dr., Suite 100,
San Antonio, TX 78249

You will be contacted once your request to join is processed.

How do I get help with this form?

Call Community First Health Plans at 210-358-6386. TTY users can call 1-800-390-1175.

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

En español: Llame a Community First Health Plans al 210-358-6386, TTY 1-800-390-1175.

O llame a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Este formulario de solicitud está disponible en español en nuestro sitio web communityfirstmedicare.com.

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

Select the plan you want to join:

☐ Community First MAPD Standard Plan (HMO) H5447-001

☐ Community First MAPD D-SNP Standard Plan (HMO D-SNP) H5447-002

First Name:	Last Name:	MI (Optional):

Birth Date: (mm/dd/aaaa)	Sex: ☐ Male ☐ Female	Phone Number: ( )

Permanent Residence Street Address (Do not enter a PO Box):	County (Optional):	State:	ZIP Code:

City

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 Community First Medicare Advantage Plan?

☐ Yes ☐ No

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

If Community First MAPD D-SNP Standard Plan (HMO D-SNP) H5447-002 is selected (All must be *Yes* to be eligible):

Are you are entitled to Medicare Part A? ☐ Yes ☐ No

Are you enrolled in Medicare Part B? ☐ Yes ☐ No

Are you enrolled in the Texas Health and Human Services Medicaid program? ☐ Yes ☐ No

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

IMPORTANT: Read and sign below:

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

( )

Phone Number

Address

Relationship to Enrollee

Section 2 – All fields on this page are optional

Answering these questions is your choice. You can not 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 Community First Medicare Advantage Plan at 210-358-6386 if you need information in an accessible format other than what is listed above. Our office hours are 7 days a week from 8 a.m. to 8 p.m. TTY users can call 1-800-390-1175.

Do you work?

☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center:

I want to get the following materials via email. Select one or more.
☐ Summary of Benefits ☐ Evidence of Coverage (EOC)

E-mail address:

- I give consent for all entities under Community First Health Plans and any outside vendor used by Community First Health Plans to call the phone number(s) I have provided.
- If I get help from a sales agent, broker or someone who has a contract with the plan, the plan may pay that person for this help.
- The information on this 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.
- My response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

When I sign, it means that I have read and understand the information on this form.

If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (Power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and you have received your Community First Health Plans member ID card, please call our Member Services at the number on the back of your Community First Health Plans member ID card to update your authorization information on file.

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.

Attestation of Eligibility for an Enrollment Period

Referenced in section: 30.4
(Rev. 2, Issued: August 25, 2020; Effective/Implementation: 01-01-2022)

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 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) _____ .

☐ 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 received 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 received 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 have not 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 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 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 applies to you or you are not sure, please contact Community First Medicare Advantage Plan at 210-358-6386 (TTY users should call 1-800-390-1175) to see if you are eligible to enroll. We are open 7 days a week from 8 a.m. to 8 p.m.