COMMUNITY FIRST
HEALTH PLANS

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN COMMUNITY FIRST MEDICARE ADVANTAGE ALAMO PLAN OR DUAL ELIGIBLE SPECIAL NEEDS PLAN (D-SNP) (HMO)

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Who can use this form?
People with Medicare who want to join Community First Medicare Advantage Alamo Plan or D-SNP.

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 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?
- 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.

What happens next?
Send your completed and signed form to:

Community First Health Plans, Inc.
Member Services – Medicare Enrollment
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 Medicare Advantage Plans at 210-358-6386 or 1-833-434-2347 (toll-free) 7 days a week, from 8 a.m. to 8 p.m. (October 1 - March 31); Monday through Friday, from 8 a.m. to 8 p.m. (April 1 - September 30); Message service available on weekends and holidays from April 1 - September 30. TTY users can call 711 (24 hours a day/7 days a week)

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

En español: Llame a Planes de Community First Medicare Advantage al 210-358-6386 o 1-833-434-2347 (gratis) los 7 días de la semana, de 8 a.m. a 8 p.m. (1 de octubre al 31 de marzo); de lunes a viernes, de 8 a.m. a 8 p.m. (1 de abril al 30 de septiembre); Servicio de mensajes disponible los fines de semana y días festivos a partir del 1 de abril al 30 de septiembre. Los usuarios de TTY pueden llamar al 711, 24 horas al día/7 días de la semana.

O, llame a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

OMB No. 0938-1378 Expires: 6/30/2026 H5447_0823M00224_M

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

Select the plan you want to join:

☐ Community First Health Plans Medicare Advantage Alamo Plan (HMO)
(Community First MAPD Standard Plan (HMO) H5447-001)

☐ Community First Health Plans Medicare Advantage Dual Eligible Special Needs Plan (HMO D-SNP)
(Community First MAPD D-SNP Standard Plan (HMO D-SNP) H5447-002)

FIRST name:	LAST name:	[Optional: Middle Initial]:

Birth date: (MM/DD/YYYY)	Sex: ☐ Male ☐ Female	Phone Number: ( )

Permanent Residence street address:

City:	[Optional: County]:	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:

Please Answer These Important Questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Community First Medicare Advantage Alamo Plan or D-SNP?

☐ Yes ☐ No

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

Please complete this section only if Community First MAPD D-SNP Standard Plan (HMO D-SNP) H5447-002 is selected. (All must be *Yes* to be eligible.):

1. Are you are entitled to Medicare Part A? ☐ Yes ☐ No
2. Are you enrolled in Medicare Part B? ☐ Yes ☐ No
3. Are you enrolled in the Texas Health and Human Services Medicaid program? ☐ Yes ☐ No
4. Please enter your Medicaid ID number printed on your Your Texas Benefits Member ID card.

   Medicaid Number:

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 Health Plans Medicare Advantage Alamo Plan or D-SNP.
- By joining this Medicare Advantage Plan, I acknowledge that Community First Health Plans 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 Medicare Advantage plan at a time – and that enrollment in this plan will automatically end my enrollment in another Medicare Advantage plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Community First Medicare Advantage Alamo Plan or D-SNP coverage begins, I must get all of my medical and prescription drug benefits from Community First Medicare Advantage Alamo Plan or D-SNP. Benefits and services provided by Community First Medicare Advantage Alamo Plan or D-SNP and contained in my Community First Medicare Advantage Alamo Plan or D-SNP "Evidence of Coverage" document (also known as a "member contract" or "subscriber agreement") will be covered. Neither Medicare nor Community First Medicare Advantage Alamo Plan or D-SNP 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.

Signature _____ Today's date _____

If you're 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'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**

Whats your race?

- ☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer.**

What is your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term:_____
- ☐ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term:_____
- ☐ I don't know
- ☐ **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 ☐ Data CD

Please contact Community First Medicare Advantage Plan at 210-358-6386 or 1-833-434-2347 (toll-free) 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. (October 1 – March 31); Monday through Friday, from 8 a.m. to 8 p.m. (April 1 – September 30). Message service available on weekends and holidays from April 1 – September 30. TTY users can call 711, 24 hours a day/7 days a week.

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

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

PCP ID#:

Name of PCP:

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

☐ Summary of Benefits ☐ Evidence of Coverage (EOC)

Email address:

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.

Proposed Effective Date: _____

Agent Name/National Producer Number:

_____

Please return to:

Community First Health Plans
12238 Silicon Dr., Suite 100
San Antonio, TX 78249
Fax: 210-358-6019
Email: DL_Enrollment_Medicare_Advantage@cfhp.com

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 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 apply to you or you are not sure, please contact Community First Medicare Advantage Plan at 1-833-434-2347 (toll-free) or 210-358-6386 (local) to see if you're eligible to enroll. You can call 7 days a week, from 8 a.m. to 8 p.m. (October 1 – March 31); Monday through Friday, from 8 a.m. to 8 p.m. (April 1 – September 30). Message service is available on weekends & holidays from April 1 – September 30. TTY users can call 711, 24 hours a day/7 days a week.

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SCOPE OF SALES APPOINTMENT CONFIRMATION FORM

The Centers for Medicare and Medicaid Services (CMS) requires agents to document the scope of a marketing appointment prior to any individual sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or their authorized representative.

Please check beside the type of product(s) you want the agent to discuss. (See product descriptions on page 2.)

- ☐ **STAND-ALONE MEDICARE PRESCRIPTION DRUG PLANS (PART D)**
- ☐ **DENTAL/VISION/HEARING PLANS**
- ☐ **MEDICARE ADVANTAGE PLANS (PART C)**
- ☐ **HOSPITAL INDEMNITY PLANS**
- ☐ **MEDICARE SUPPLEMENT (MEDIGAP) PLANS**

Beneficiary or Authorized Representative Signature and Signature Date

Signature _____ Today's date _____

If you're the authorized representative, sign above and fill out these fields:

Name _____ Phone Number _____

Address _____ Relationship to enrollee _____

By signing this form:

- » I agree to a meeting with a sales agent to discuss the types of products initialed above.
- » I give consent for all entities under Community First Health Plans, Inc. and any outside vendor used by Community First Health Plans, Inc. to call the phone number(s) I provided.

Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment, or enroll you in a Medicare plan. Please note, the plan may pay the sales agent, broker, or someone who has a contract with the plan for this help. They do not work directly for the Federal government.

STAND-ALONE MEDICARE PRESCRIPTION DRUG PLANS (PART D)

Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

MEDICARE ADVANTAGE PLANS (PART C) AND COST PLANS

Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

OTHER RELATED PRODUCTS

Dental/Vision/Hearing Products — Plans offering additional benefits for consumers who are looking to cover needs for dental, vision, or hearing. These plans are not affiliated or connected to Medicare.

Hospital Indemnity Products — Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray co-pays/co-insurance. These plans are not affiliated or connected to Medicare

Medicare Supplement (Medigap) Products — Insurance plans that help pay some of the out-of-pocket costs not paid by Original Medicare (Parts A and B) such as deductibles and co-insurance amounts for Medicare approved services.

TO BE COMPLETED BY AGENT

Agent Name / National Producer Number:	Agent Phone:
Beneficiary First and Last Name:	Beneficiary Phone:
Beneficiary Address:	
Plan(s) the agent represented during this meeting:	Date Appointment Completed:
Initial Method of Contact: (Indicate here if beneficary was a walk-in.)	
Agent's Signature:	

Please return page 1 and 2 of this form to:
Community First Health Plans
12238 Silicon Dr., Suite 100
San Antonio, TX 78249
Fax: 210-358-6019
Email: DL_Enrollment_Medicare_Advantage@cfhp.com

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