OMB No. 0938-1378
Expires:7/31/2023

2021 Medicare Advantage Enrollment Form

Eastern Idaho

Bannock, Bingham, Bonneville, Jefferson, and Madison Counties

PacificSource Medicare

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug 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 January1)
- 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:

Email: medicareapplications@pacificsource.com
Mail: PacificSource Medicare, PO Box 7469, Bend, OR 97708
Enroll Online: www.Medicare.PacificSource.com
Fax: (541) 382-4217 or (855) 382-4217 toll-free

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

How do I get help with this form?

If you have questions, please call PacificSource Medicare Customer Service Department toll-free at **(888) 863-3637** or **TTY 711.** We're always happy to help you.

October 1 - March 31:
8:00 a.m. - 8:00 p.m., seven days a week
April 1 - September 30:
8:00 a.m. - 8:00 p.m., Monday - Friday

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

En español: Llame a PacificSource Medicare al (888) 863-3637 or 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.

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-NEW. 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.

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

Select the plan you want to join:

☐ **$0/mo** Explorer 12 (PPO)
☐ **$79/mo** Essentials Rx 21 (HMO)
☐ **$99/mo** Explorer Rx 9 (PPO)

Optional Dental: Dental plans are in addition to your monthly plan premium

☐ Preventive Dental: $23
☐ Comprehensive Dental: $47

First Name _____ Last Name _____ (Optional) MI ____

Birth Date (MM/DD/YYYY) _____/_____/_____ Sex ☐ M ☐ F Phone (_____)_____-_____

Requested Effective Date (MM/DD/YYYY) _____/_____/_____

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

Permanent Residence Street Address (Don't enter a PO Box):

_____

City _____ County _____ State _____ ZIP _____

Email _____

Mailing Address, if different from your permanent address (PO Box Allowed):

Street Address _____

City _____ State _____ ZIP _____

Your Medicare Information: Medicare Number _____

Please read and answer these important questions:

1. **Are you enrolled in your State Medicaid program?** ☐ Yes ☐ No Medicaid Number _____
2. **Will you have, or have you had, other medical and/or prescription drug coverage in addition to your Medicare coverage and PacificSource Medicare?** (For example, other private insurance, TRICARE, Federal employee health benefits, or VA benefits, or State pharmaceutical assistance programs.) ☐ Yes ☐ No

   If "yes," please include: Effective Date _____/_____/_____ Termination Date _____/_____/_____

   Subscriber Name _____ Insurance Company _____

   Group Name _____ ID Number _____ Group Number _____
3. **Are you a resident in a long-term care facility, such as a nursing home?** ☐ Yes ☐ No **If "yes," provide:**

   Name of Institution _____ Phone Number of Institution (_____)_____-_____

   Institution Address (number and street) _____

For agent use only:

Agent Name _____
Agent ID PM _____ **Date Received by Agent** _____/_____/_____

IMPORTANT: Read and sign below

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

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

Name _____ Address _____

Phone Number _____ Relationship to Enrollee _____

Section 2 – All fields below are optional

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

Select 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 PacificSource Medicare at (888) 863-3637 or TTY 711 if you need information in an accessible format other than what's listed above. Our office hours are October 1 - March 31: 8:00 a.m. - 8:00 p.m., seven days a week; April 1 - September 30: 8:00 a.m. - 8:00 p.m., Monday - Friday.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

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

☐ Evidence of Coverage ☐ Explanation of Benefits ☐ Annual Notice of Change ☐ Newsletters

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) with one of the options below. *Note: If you don't select an option, we'll keep your current option or send you a bill.* If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it.

☐ **Get a monthly bill.**

☐ **Automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check.**
I get monthly benefits from ☐ Social Security ☐ RRB

Continued on next page >

☐ **Automatic deduction from your checking account each month. Please include a voided check or provide the following:**

Account Holder Name _____ Bank Routing Number _____

Bank Account Number _____ Account Type: ☐ Checking ☐ Savings

Automatic deductions are made on the 5th day of every month. Deductions include any outstanding balance on your account. If the deduction falls on a weekend or holiday, the deduction will occur the next business day. Please provide a voided check (deposit slips not accepted). You can stop deductions from your account by notifying us at the phone number or address on page 4 at least 30 days prior to the deduction date.

☐ **Credit card.** Once you're enrolled, we'll send you information about setting up credit card payments.

☐ **PERSI.** If you select PERSI, **you must complete the PERSI premium payment information section below.**

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 PacificSource Medicare the Part D-IRMAA.

PERSI premium payment information

Please complete the following to setup payments using your PERSI funds:

Note: You are responsible for paying your premium until we notify you of your start date

I am a State of Idaho/Statewide Schools ☐ Retiree ☐ Requesting payment from my spouse, who is a PERSI retiree.

Retiree Name _____ Retiree SSN _____

School District Name _____

Section 3 – Please confirm your eligibility for an enrollment period

☐ I'm enrolling during the annual enrollment period (October 15 – Dec 7).

☐ I'm 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 the service area of my current plan, or recently moved, and this is a new option for me. I moved on _____ (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 get Extra Help paying for Medicare prescription drug coverage effective _____ (date).

☐ I was enrolled in a Special Needs Plan (SNP) but have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on _____ (date).

☐ I was affected by a weather-related emergency OR major disaster (as declared by the Federal Emergency Management Agency (FEMA) OR declared emergencies by a federal, state or local government). None of the other statements here applied to me, but I was unable to make my enrollment because of the declared emergency.

☐ None of the above statements apply to me. I feel I have a special circumstance which allows me an exception to enroll. Please include the reason:

PacificSource Community Health Plans is an HMO/PPO plan with a Medicare contract. Enrollment in PacificSource Medicare depends on contract renewal.

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.