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2024 Medicare Advantage Enrollment Form

Inland Northwest and Puget Sound Area

Idaho: Bonner, Boundary, and Kootenai Counties
Washington: Clark, Pierce, and Spokane 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:

- From October 15 to 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:

Email: MedicareApplications@PacificSource.com

Mail: PacificSource Medicare, PO Box 7469, Bend, OR 97708

Enroll Online: 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?

Call PacificSource Medicare Customer Service at **888-863-3637** or TTY: 711. We accept all relay calls.

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 (aceptamos llamadas del servicio de retransmisión) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness
If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

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Section 1 – All fields in this section are required (unless marked optional)

Select your plan:

☐	**$0/mo**	Explorer 12 (PPO)
☐	**$0/mo**	Explorer Rx 11 (PPO)
☐	**$0/mo**	MyCare™ Choice Rx 34 (HMO-POS)
☐	**$0/mo**	MyCare™ Choice 30 (HMO-POS)

First name _____ Last name _____ MI ____ (Optional)

Birth date _____ Gender ☐ M ☐ F **Requested effective date** _____

List your primary care provider (PCP) (Optional) _____

Permanent residence (PO Box not allowed):

Street address _____

City _____ County _____ State _____ ZIP _____

Phone _____ Email _____

Mailing address, if different from your permanent address:

Street address _____

City _____ State _____ ZIP _____

Your Medicare information: **Medicare number** _____

Please read and answer these important questions:

1. **Are you a current PacificSource member?** ☐ Yes ☐ No
2. **Are you enrolled in your state Medicaid program?** ☐ Yes ☐ No **Medicaid number** _____
3. **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 _____
4. **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 broker use only:

Broker name _____

Broker ID PM _____ **Date received by broker** _____

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 on page 4.) 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 Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D plan.
- 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.
- 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 _____ 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.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply:

- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Cuban
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ I choose not to answer

What's your race? Select all that apply:

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

Select if you want us to send you information in a language other than English. ☐ Spanish ☐ Other _____

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 (we accept all relay calls) 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 (your member handbook)
- ☐ Formulary (the list of covered drugs)
- ☐ Pharmacy Directory (the list of in-network pharmacies)
- ☐ Provider Directory (the list of in-network providers)

Email address _____

Section 3 – 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.

☐ **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

☐ **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 1 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. 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. DON'T pay PacificSource Medicare the Part D-IRMAA.

☐ **Idaho residents: 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.

Idaho residents: 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 4 – Please confirm your eligibility to enroll (Please check all that apply)

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 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 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 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 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 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 of 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're not sure, please contact PacificSource Medicare at **888-863-3637** (TTY users should call 711) to see if you are eligible to enroll. We are open 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.

PacificSource Community Health Plans is an HMO, HMO D-SNP, and PPO plan with a Medicare contract and a contract with Oregon Health Plan (Medicaid). 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) Plans, improve care, and for the payment of Medicare benefits. Sections 1860D-1 of the Social Security Act and 42 CFR §§ 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.