CDPHP® Medicare Advantage
GROUP HMO & PPO PLANS
MEMBER APPLICATION

APPLICANT: Please print and use ink. If you have questions about benefits, pharmacy, or the CDPHP provider network, call CDPHP member services at (518) 641-3950 or toll free at 1-888-248-6522 (TTY 711).

Our hours are 8 a.m.–8 p.m. seven days a week, October 1–March 31.
From April 1–September 30, Monday–Friday, our hours are 8 a.m.–8 p.m.
A voice messaging service is used weekends, after-hours, and federal holidays.
Calls will be returned within one business day. TTY users should call 711.

Please contact your employer for information about enrollment and premiums.

EMPLOYER GROUP/BROKER:
Complete the "Employer Group Office Use Only" section at the beginning of the application.

Scan and email to: MedicareEligibility@cdphp.com or fax to: (518) 641-5006

CDPHP Group Medicare Enrollment Application

FOR EMPLOYER GROUP OFFICE USE ONLY		
Employer Group Admin Initials *(required)*:	Effective Date:	QE or Reason: ☐ ICEP/IEP ☐ OEP ☐ AEP ☐ SEP
Employer or Union Name:		Group #:

Please note: By submitting this application, you attest that the member below is not working and/or eligible to receive employer or union benefits. (Only applies to groups >20 employees.) If the applicant is currently enrolled in a CDPHP active offering through your group, please disenroll through your standard procedure (i.e. electronic enrollment file, secure portal, enrollment/change form).

Please provide the following to Enroll in CDPHP Group Medicare Advantage			
LAST Name:			Plan Choice: ☐ HMO ☐ PPO
FIRST Name:			Middle Initial:
Birth Date: __/__/____	Sex: ☐ M ☐ F	Home Phone Number: (_____) _____ - _____	Mobile Phone Number: (_____) _____ - _____
Permanent Physical Residence Street Address (P.O. Box is not allowed):			
City:	County:	State:	Zip Code:
Mailing Address (only if different from your permanent residence address):			
City:	County:	State:	Zip Code:
Email Address:			
Name of Primary Care Physician (Complete for CDPHP Medicare Advantage Group HMO plans only): Physician Name:			

Return completed application to your employer.
Employer: Complete Employer Use Section then email to MedicareEligibility@cdphp.com or fax to (518) 641-5006

CDPHP Group Medicare Enrollment Application

Please provide the following to Enroll in CDPHP Group Medicare Advantage

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

–OR–

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name *(as it appears on your Medicare card)*:

_____

Medicare Number: _____

Is Entitled To: Effective Date:

HOSPITAL (Part A) _____/_____/_____

MEDICAL (Part B) _____/_____/_____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

If you would prefer us to send you information in Large Print, please check the box. ☐ Large Print

Please contact CDPHP Medicare Advantage at (518) 641-3950 or 1-888-248-6522 if you need information in a format or language other than what is listed above. TTY/TDD users should call 711. Our hours are 8 a.m.–8 p.m. seven days a week, October 1–March 31. From April 1–September 30, Monday–Friday, our hours are 8 a.m.–8 p.m. A voice messaging service is used weekends, after-hours, and federal holidays. Calls will be returned within one business day.

Please read and answer these important questions

1. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No

   If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis. Otherwise, we may need to contact you to obtain additional information.

2. When your CDPHP Group Medicare coverage takes effect, will you (on your own or through your spouse) have other **health insurance** in addition to CDPHP, including the types listed above? ☐ Yes ☐ No
   If "**yes**," please list the name of your other coverage and your identification number:

   Insurance Carrier Name: _____

   Policyholder Name: _____ ID #: _____

3. When your CDPHP Group Medicare coverage takes effect, will you (on your own or through your spouse) have other **prescription drug coverage** in addition to CDPHP, including the types listed above? ☐ Yes ☐ No
   If "**yes**," please list the name of your other coverage and your identification number:

   Insurance Carrier Name: _____

   Policyholder Name: _____ RxBIN #: _____

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4. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
If "**yes**," please provide the following information:

Name of Institution: _____

Address of Facility (number and street): _____

_____ Phone Number: _____

5. Are you enrolled in your state Medicaid program? ☐ Yes ☐ No

If "**yes**," please provide your Medicaid number: _____

6. Are you the retiree? ☐ Yes ☐ No If "**yes**," retirement date: _____ / _____ / _____

If "**no**," name of retiree: _____

If "**yes**," name of spouse (if enrolling): _____

Please contact your group administrator for assistance with enrolling eligible family members. A separate application is needed for each person to be enrolled in this plan.

7. Do you or your spouse (if enrolling) work?

You: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No ☐ N/A

STOP! PLEASE READ THE IMPORTANT INFORMATION ON THE REVERSE AND SIGN BELOW:
(Applicant's signature date must be prior to effective date.)

Applicant's Signature:	**Today's Date:**

If you are the applicant's authorized representative, you must provide the following information:

Name: _____

Address: _____

Telephone Number: (_____) _____ - _____ Relationship to Enrollee: _____

Attach a copy of proof of Legal Guardian, DPAHC, written advance directive, or proof of authorization by the state.

Office Use Only:	**Date Received**
Name of Staff member/agent/ broker (if assisted in enrollment): _____ Signature: _____ Broker ID: _____	

Return completed application to your employer.
Employer: Complete Employer Use Section then email to MedicareEligibility@cdphp.com or fax to (518) 641-5006

CDPHP Group Medicare Enrollment Application

STOP! PLEASE READ THIS IMPORTANT INFORMATION:

By completing this enrollment application, I agree to the following:

CDPHP is a Medicare Advantage plan and has a contract with the federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I already have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire benefit period. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to my employer or union health benefits department.

CDPHP Group Medicare Plans serve a specific service area. If I move out of the area that my CDPHP Group Medicare Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of a CDPHP Group Medicare Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from my CDPHP Group Medicare Plan when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country, except for limited coverage near the U.S. border.

I understand that beginning on the date my CDPHP Group Medicare Plan coverage begins, I must get all of my health care in accordance with my CDPHP Group Medicare Plan, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by my CDPHP Group Medicare Plan and other services contained in my CDPHP Group Medicare Plan's *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MY CDPHP GROUP MEDICARE PLAN WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with CDPHP Group Medicare Plans, he/she may be paid based on my enrollment in CDPHP Group Medicare Plans.

Release of Information:

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that my CDPHP Group Medicare Plan will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes, which follow all applicable federal statutes and regulations. 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 authorized to act on behalf of the individual under the laws of the state where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (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 from Medicare.

Return completed application to your employer.
Employer: Complete Employer Use Section then email to MedicareEligibility@cdphp.com or fax to (518) 641-5006

Discrimination is Against the Law

Capital District Physicians' Health Plan, Inc. (CDPHP®) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CDPHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CDPHP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the CDPHP Civil Rights Coordinator.

If you believe that CDPHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: CDPHP Civil Rights Coordinator, 500 Patroon Creek Blvd., Albany, NY 12206, 1-844-391-4803 (TTY/TDD: 711), Fax (518) 641-3401. You can file a grievance by mail, fax, or electronically at https://www.cdphp.com/customer-support/email-cdphp. If you need help filing a grievance, the CDPHP Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-language Interpreter Services

ATTENTION: If you speak a non-English language, language assistance services, free of charge, are available to you. Call 1-888-248-6522 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-248-6522 (TTY: 711)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-248-6522（TTY：711）

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-248-6522 (телетайп: 711)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-248-6522 (TTY: 711)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-248-6522 (TTY: 711)번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-248-6522 (TTY: 711)

טפור .לאצפא וופ יירפ סעסיוורעס חליה דארפש דייא ראפ ואהראפ וענעז ,שידיא טדער ריא ביוא :מאזקרעמפיוא
1-888-248-6522 (TTY: 711).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-888-248-6522 (TTY: 711)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-248-6522 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-248-6522 (رقم
هاتف الصم والبكم: 117

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-248-6522 (ATS : 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال
کریں.(TTY: 711) 1-888-248-6522

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-248-6522 (TTY: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-888-248-6522 (TTY: 711)

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-248-6522 (TTY: 711)