A plan for life.

CDPHP® Medicare Advantage

GROUP HMO & PPO PLANS

MEMBER APPLICATION

Y0019_GR21_13435_C

20-13435

Group Enrollment Request Form to Enroll in a Medicare Advantage Plan (Part C)

Who can use this form?

People with Medicare who are eligible to join their employer based Medicare Advantage Plan.

To join a plan, you must:

- Reach out to your employer to confirm eligibility for this plan
- 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)

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.

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 ot 1-888-248-6522 (TTY:711).

Reminders:

- Your application must be completed and submitted to your employer prior to your requested effective date.
- Contact your employer for information about enrollment and to confirm premium amount and payment responsibilities.

What happens next?

- Send your completed and signed form to your employer prior to the requested effective date.
- Once your enrollment is processed, you will receive ID cards (with a new ID number) and a welcome packet in the mail.
- If you previously had a non-Medicare CDPHP plan, you will receive a letter telling you that we have ended your membership in that plan. This is a necessary step, but rest assured, you are covered by your new Group Medicare Advantage Plan.

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).

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

Select the plan you want to join:
☐ HMO ☐ PPO

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

Birth Date: (MM/DD/YYYY)	**Sex:**	**Home Phone Number:**	**Mobile Phone Number:**
__ __ / __ __ / __ __ __ __	☐ M ☐ F	(_____) _____-_____	(_____) _____-_____

Permanent Residence street address (Don't enter a PO Box):

City:	**[Optional: County]:**	**State:**	**ZIP Code:**

Mailing address, if different from your permanent address (PO Box allowed):
Street Address: City: State: ZIP Code:

E-mail address (Optional)

Your Medicare information:

Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __

Answer these important questions:

Will you have other presciption drug coverage (like VA, TRICARE) in addition to CDPHP? ☐ Yes ☐ No

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

_____ _____ _____

Are you the retiree? ☐ Yes ☐ No If "Yes", retirement date __ __ / __ __ / __ __ __ __

If "No" name of retiree ☐ Yes ☐ No 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.

CDPHP Group Medicare Enrollment Application

Section 1 – All fields on this page are required (unless marked optional) ***(continued from previous page)***

IMPORTANT: Read carefully before signing

- I must keep both Hospital (Part A) and Medical (Part B) to stay in CDPHP.
- By joining this Medicare Advantage Plan, I acknowledge that CDPHP 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 CDPHP coverage begins, I must get all of my medical and prescription drug coverage benefits from CDPHP. Benefits and services provided by CDPHP and contained in my CDPHP "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CDPHP will pay for benefits that are not covered.
- If I am enrolled in a PPO plan, I understand that when my CDPHP coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services. If medically necessary, CDPHP provides refunds for all covered services, even if I get services out of network.
- 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.

Section 2 – All fields in this section are optional

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

Please contact CDPHP Medicare Advantage at (518) 641-3950 or 1-888-248-6522 if you need information in another language or format (Braille). Our office 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 after hours, weekends, and on federal holidays. Calls will be returned within one business day. TTY users can call 711.

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

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

Signature **Today's date:**

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

Name: Address:

Phone Number: Relationship to enrollee:

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment):

_____

Signature: _____ Broker ID: _____

DATE RECEIVED

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.

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 זוף יירפ סעסיוורעס חליה דארפש דייא ראפ זאהראפ זענעז ,שידיא טדער ריא ביוא :סאזקרעמפיוא
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)

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Capital District Physicians' Health Plan, Inc.
500 Patroon Creek Boulevard, Albany, NY 12206-1057

www.cdphp.com

20-13435