OMB No. 0938-1378
Expires:7/31/2024

# 2023 Individual Enrollment Request Form

If you have questions, please contact AgeWell New York at:
**1-866-237-3210** or TTY/TDD **1-800-662-1220**
Fax Enrollment form to **1-855-895-0784**

## 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:
AgeWell New York
ATTN: Medicare Enrollment
1991 Marcus Avenue, Suite M107
Lake Success, NY 11042

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

## How do I get help with this form?

Call AgeWell New York at **1-866-237-3210**. TTY/TDD users can call **1-800-662-1220.**

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

**En español:** Llame a AgeWell New York al **1-866-237-3210**. TTY/TDD **1-800-662-1220** o a Medicare gratis al **1-800-633-4227** y oprima el 2 para asistencia en español y un representante estará disponible para asistirl.

## 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.



**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.**

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

### SELECT THE PLAN YOU WANT TO JOIN

| | |
|---|---|
| **Bronx, Kings (Brooklyn), Nassau, New York (Manhattan), Queens, & Westchester** | |
| **HMO** | □ **LiveWell (HMO) (H4922-011)** **$0** per month<br>□ **Add Optional Dental $15** per month □ **Add Optional Vision $8.30** per month |
| **HMO DSNP** | □ **FeelWell (HMO D-SNP) (H4922-003)** **$0** per month<br>Full Medicaid (QMB+/SLMB+) or QMB Only |
| **MAP** | □ **AgeWell New York Advantage Plus (HMO D-SNP) (H4922-010)** **$0** per month<br>Full Medicaid with community based long term care needs |
| **Bronx, Kings (Brooklyn), Nassau, New York (Manhattan), Queens, Suffolk & Westchester** | |
| **HMO ISNP** | □ **CareWell (HMO I-SNP) (H4922-004)** **$0 or up to $38.90** per month |

### TO ENROLL IN AGEWELL NEW YORK, PLEASE PROVIDE THE FOLLOWING INFORMATION

| | | | |
|---|---|---|---|
| FIRST Name: | LAST Name: | | (Optional) Middle Initial: |
| Birth date: (MM/DD/YYYY)<br>(_____/_____/_____) | Sex:<br>□ Male □ Female | Phone number:<br>(  ) | |
| 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):<br>Street address: | | | |
| City: | State: | | ZIP Code: |
| Emergency contact: | Phone number: | | Relationship to you: |

### Your Medicare information:

**Medicare Number:** _ _ _ _ - _ _ _ - _ _ _ _

## Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to AgeWell New York?
□ Yes □ No

| Name of other coverage: | Member number for this coverage: | Group number for this coverage: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**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 facility: _____

Address: _____

City: _____ State: _____ Zip: _____ Tel:(____)_____

**Are you enrolled in your State Medicaid program?** □ Yes □ No

If yes, please provide your Medicaid number: _____

## IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in AgeWell New York.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that AgeWell New York 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 MA plan at a time - and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA, PFFS, MA, MSA plans).
- I understand that when my AgeWell New York coverage begins, I must get all of my medical and prescription drug benefits from AgeWell New York. Benefits and services provided by AgeWell New York and contained in my AgeWell New York "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor AgeWell New York 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 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, Mexican, Mexican American, Chicano/a
□ Yes, Puerto Rican
□ Yes, Cuban
□ Yes, another 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 America
□ Chinese
□ Filipino
□ Guamanian or Chamorro
□ Japanese
□ Korean
□ Native Hawaiian
□ Other Asian
□ Other Pacific Islander
□ Samoan
□ Vietnamese
□ White
□ I choose not to answer.

Select one if you want us to send you information in a language other than English.

□ Spanish □ Chinese □ Korean □ Russian □ Other: _____

Select one if you want us to send you information in an accessible format.

□ Braille □ Large Print □ Audio CD

Please contact AgeWell New York at **1-866-237-3210** if you need information in an accessible format or language other than what is listed above. Our office hours are 7 days a week from 8:00 am to 8:00 pm Eastern time. TTY/TDD users should call **1-800-662-1220.**

**Do you work?** □ Yes □ No **Does your spouse work?** □ Yes □ No

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

**I want to get the following materials via E-mail.** □ Yes □ No

**Select one or more.**

□ Annual Notice of Change (ANOC) □ Newsletters) □ Evidence of Coverage (EOC)

**Valid E-mail address:** _____

By providing my email address above, I agree to receive email about my benefits, health programs and other plan services. I understand I can change my email preference or opt out of receiving emails at any time by calling Member Services at **1-866-237-3210** TTY/TDD users should call **1-800-662-1220.**

## PAYING YOUR PLAN PREMIUM

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail with a personal or certified check each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

**Please select a premium payment option:**

□ **Get a bill.**

**OR**

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

**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 AgeWell New York the Part D-IRMAA.

## PLEASE READ AND SIGN BELOW

**Office/Agent/Broker Use Only**

Name of Staff Member/Agent/Broker (if assisted in enrollment): _____

Plan ID #:_____ Effective Date of Coverage: _____

ICEP/IEP:_____ AEP:_____ DUAL LIS/SEP (specify type):_____

Other Election Period (specify type: i.e. MAOEP, OEP, etc.): _____ Not Eligible: _____

Enrollment Department Agent/Broker Application Receive Date: _____

Agent/Broker NPN ID#: _____

Please print all information in black ink - keep the yellow copy for your records.

You can Fax this Enrollment Form to **1-855-895-0784**

You can also Mail all other documents or payments to:

**AgeWell New York,**
**1991 Marcus Avenue, Suite M107,**
**Lake Success, New York, 11042**

### 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.

AgeWell New York, LLC is a Health Maintenance Organization (HMO) plan with a Medicare contract. AgeWell New York, LLC has a State Medicaid Agency Contract with New York State Department of Health, and a New York State Medicaid contract for AgeWell New York Advantage Plus (HMO D-SNP). Enrollment in AgeWell New York, LLC depends on contract renewal. ATTENTION: If you speak Spanish, language assistance services are available to you free of charge. Call **1-866-237-3210 (TTY/TDD: 1-800-662-1220)**. ATENCIÓN: si hablas español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-237-3210 (TTY/TDD: 1-800-662-1220)**. Assistance services for other languages are also available free of charge at the number above.

**Notice of Nondiscrimination**

AgeWell New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AgeWell New York does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. AgeWell New York 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)
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact AgeWell New York Member Services at **1-866-237-3210**.
If you believe that AgeWell New York 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:

AgeWell New York
**Civil Rights Coordination Unit**
1991 Marcus Avenue Suite M107
Lake Success, New York 11042-2057
**1-866-237-3210**
TTY/TDD: **1-800-662-1220**
Fax: **855-895-0778**
Email: civilrightsunit@agewellnewyork.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordination Unit 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**, TTY/TDD: **1-800-537-7697**. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.