healthfirst®
Health Insurance for New Yorkers

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

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A HEALTHFIRST MEDICARE ADVANTAGE PLAN

Who can use this form?

People with Medicare who want to join a Healthfirst Medicare Advantage plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in Healthfirst's service area

Important: To join a Healthfirst 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 Healthfirst Medicare Advantage Plan:

- Between October 15 and December 7 each year (for coverage starting January 1)
- Within three 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 ID number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Sections 1, 2, 3, 4, 7, and 8. The items in Sections 5 and 6 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), Healthfirst must get your completed form by December 7.
- Healthfirst will send you a bill for the plan's premium, if applicable. 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:

Healthfirst Medicare Plan
P.O. Box 5193
New York, NY 10274-5193

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

How do I get help with this form?

Call Healthfirst Medicare Plan at **1-877-237-1303**. TTY users can call 1-888-542-3821. Or, call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users can call 1-877-486-2048.

En español: Llame a Healthfirst Medicare Plan al **1-877-237-1303** (TTY 1-888-867-4132) 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.

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. They 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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Enrollment Request Long Form

Mail original copies to Healthfirst Medicare Plan, **P.O. Box 5193, New York, NY 10274-5193**.
Please contact Healthfirst Member Services if you need this form in another language or format.

Section 1 | Select the Plan You Want to Join

- ☐ CompleteCare (HMO D-SNP) [H3359-034—$0.00 premium]
- ☐ Life Improvement Plan (HMO D-SNP) [H3359-021—$0.00 premium]
- ☐ Increased Benefits Plan (HMO) [H3359-019—$29.60* premium
- ☐ 65 Plus Plan (HMO) [H3359-001—$0.00 premium]
- ☐ Healthfirst Signature (PPO) [H9678-001—$0.00 premium]
- ☐ Healthfirst Signature (HMO) [H5989-011—$0.00 premium]
- ☐ Healthfirst Signature (HMO) [H1722-002—$0.00 premium]

For Healthfirst Signature (HMO), choose one of the following Choice Extras benefits:

- ☐ Over-the-counter (OTC) allowance
- ☐ Transportation

*The premium amount may be reduced or waived if you are receiving Low Income Subsidy or Extra Help.
For more information on Healthfirst Signature (HMO) Choice Extras benefits, please see the plan Summary of Benefits.

Section 2 | Individual Information

Last Name	First Name	M.I.	Gender ☐ M ☐ F	Date of Birth (MM/DD/YYYY) / /
Permanent Residence Street Address (don't enter a P.O. Box)				
City		State		Zip Code
Mailing address, if different from your permanent address (P.O. Box allowed)				
City		State		Zip Code
Home Phone (Area Code & Number) ( )	Cell Phone (Area Code & Number) ( )			

By providing this information, I authorize Healthfirst to contact me using automated means, including email, phone, or text, about Healthfirst products, services, and health-related information. Message and data rates may apply.

Section 3 | Your Medicare Information

Medicare Number												

Section 4 | Important Questions and Information

1. **Will you have other prescription drug coverage (like VA, TRICARE) in addition to Healthfirst Medicare Plan?** ☐ **Yes** ☐ **No**

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

   Group number for this coverage: _____

2. **Are you enrolled in your State Medicaid program?** ☐ **Yes** ☐ **No**

   If "yes," please provide your Medicaid (CIN) number: ☐☐☐☐☐☐☐☐

Additional Special Needs Criteria for Healthfirst Life Improvement Plan, Healthfirst Connection Plan, and Healthfirst CompleteCare

If you are enrolling in Healthfirst Life Improvement Plan, or Healthfirst CompleteCare, you must also meet these additional Special Needs requirements.

Healthfirst Life Improvement Plan (HMO D-SNP)

- You must have full Medicaid benefits or be eligible for Medicare cost-sharing assistance under Medicaid
- (Healthfirst Connection Plan only) You must currently be enrolled in our Medicaid or Personal Wellness Plan (HARP)

Healthfirst CompleteCare (HMO D-SNP)

- You must have full Medicaid benefits
- You must be 18 years of age or older
- You must be eligible for a nursing home level of care at time of enrollment using the Uniform Assessment System (UAS)
- You must be capable, at the time of enrollment, of returning to or remaining in your home and community without jeopardy to your health and safety
- You are expected to require at least one (1) of the following Community-Based Long-Term Care Services (CBLTCS) covered by Healthfirst CompleteCare for more than 120 days from the effective date of enrollment
  - nursing services in the home
  - therapies in the home
  - home health aide services
  - personal care services in the home
  - adult day healthcare
  - private duty nursing
  - Consumer Directed Personal Assistance Services

Section 5 | Your Primary Care Provider (PCP)

For HMO, Healthfirst will assign you a PCP if you do not choose one.

Primary Care Provider Name: _____

Primary Care Provider Phone Number: _____

Primary Care Provider Identification Number: _____

Section 6 | Other Information (all fields in this section are optional)

1. I want to receive my plan documents (such as my Evidence of Coverage, Annual Notice of Change, and other plan materials) through email communications from Healthfirst. I understand that I may opt out at any time and receive hard copies of my Healthfirst Medicare plan documents by calling Healthfirst.
   Email address: _____
2. Are you Hispanic, Latino/a, or of Spanish origin? Select all that apply.
   ☐ No, not Hispanic, Latino/a, or of Spanish origin ☐ Yes, Puerto Rican
   ☐ Yes, another Hispanic, Latino/a, or Spanish origin ☐ Yes, Mexican, Mexican American, Chicano/a
   ☐ Yes, Cuban ☐ I choose not to answer.
3. What's your race? Select all that apply.
   ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Chinese
   ☐ Japanese ☐ Vietnamese ☐ Asian Indian ☐ Filipino ☐ Korean ☐ Other Asian
   ☐ Guamanian or Chamorro ☐ Native Hawaiian ☐ Samoan ☐ Other Pacific Islander
   ☐ I choose not to answer.
4. Select one if you want us to send you information in a language other than English.
   ☐ Spanish ☐ Chinese
5. Select one if you want us to send you information in an accessible format.
   ☐ Braille ☐ Large print
   Please contact Healthfirst Medicare Plan at **1-888-260-1010** if you need information in an accessible format other than what's listed above. Our office hours are 8am–8pm: 7 days a week (Oct.–Mar.); Monday to Friday (Apr.–Sept.). TTY users can call **1-888-542-3821**.
6. Do you work? ☐ Yes ☐ No
7. Does your spouse work? ☐ Yes ☐ No

Section 7 | Your Plan Premium

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 or credit card monthly. **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.**

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 Healthfirst Medicare Plan the Part D-IRMAA.

Please select a premium payment option:

☐ Receive a statement and pay by check

☐ Automatic deduction from your monthly Social Security/RRB benefit check.

☐ I get monthly benefits from:
☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.) If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper statement for your monthly premium.

☐ Pay online using checking/savings account or credit/debit card. Register, or log in to, your secure Healthfirst account at **MyHFNY.org** and click "Pay Your Bill."

Section 8 | IMPORTANT: Read and sign below

Release of information:

By joining this Medicare Advantage Plan, I agree that Healthfirst Medicare Plan may release my information to Medicare, other health plans, and healthcare providers for treatment, payment, and healthcare operations. I also agree that my healthcare providers may release my information to Healthfirst Medicare Plan and other healthcare providers for treatment, payment, and healthcare operations. I also agree that the information released for treatment, payment, and healthcare operations may include HIV, mental health, or alcohol and substance abuse information about me and members of my family to the extent permitted by law, until I revoke this consent. I also acknowledge that Healthfirst Medicare Plan 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 also acknowledge that Healthfirst 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.

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

Healthfirst Medicare Plan is a plan that has a contract with the Federal government.

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

I must keep both Hospital (Part A) and Medical (Part B) to stay in Healthfirst Medicare 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).

HMO Plans: I understand that beginning on the date Healthfirst Medicare Plan coverage begins, I must get all my health care from Healthfirst Medicare Plan, except for emergency or urgently needed services or out of area dialysis services. Only medically necessary services and other services contained in my Healthfirst Medicare Plan Evidence of Coverage document (also known as the member contract) will be covered. Without authorization where required by the plan, **NEITHER MEDICARE NOR HEALTHFIRST MEDICARE PLAN WILL PAY FOR THE SERVICES**.

PPO Plans: I understand that beginning on the date Healthfirst Medicare plan coverage begins, I may use either network providers or out-of-network providers for covered services. I understand my costs may be higher if I use out-of-network providers, except for emergency or urgently needed services or out of area dialysis services. I understand that providers must be licensed and eligible to receive payment under the federal Medicare program. Only medically necessary services and other services contained in my Healthfirst Medicare Plan Evidence of Coverage document (also known as the member contract) will be covered. Without authorization where required by the plan, **NEITHER MEDICARE NOR HEALTHFIRST MEDICARE PLAN WILL PAY FOR THE SERVICES**.

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.

Member's or Authorized Representative's Signature*	Today's Date

*If you are the authorized representative, you must sign above and provide the following information:	
Name	
Relationship to Enrollee	Phone ( )
Address	Today's Date

FOR HEALTHFIRST USE ONLY								
Date Received	Plan Code	Sales Rep				Employee ID #		
Group Name	Group #	☐ QMB	☐ QMB+	☐ SLMB	☐ SLMB+	☐ QI-1	☐ QDWI	☐ FBDE
Name of Staff Member (if assisted in enrollment)		Effective Date of Coverage						
ICEP/IEP	AEP	SEP (type)				Not Eligible		

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 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.

Coverage is provided by Healthfirst Health Plan, Inc. or Healthfirst Insurance Company, Inc. ("Healthfirst"). Healthfirst Medicare Plan has HMO, PPO plans with a Medicare contract. Our SNPs also have contracts with the NY State Medicaid program. Enrollment in Healthfirst Medicare Plan depends on contract renewal. Healthfirst complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

PRA Disclosure Statement

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 0938-1378. 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.