healthfirst®
Health Insurance for New Yorkers

Enrollment Request Form Instructions

Complete this form if you wish to enroll in a Healthfirst Medicare Advantage Plan.

Section 1 | Prospect Information

- Tell us a little about yourself by completing this section. Please fill in your contact number(s) and all the required information so we can reach you if we need to verify anything.

Section 2 | Important Questions

Please complete this section to find out if you qualify for a Healthfirst Medicare Advantage plan. Check the boxes that apply to you.

1. Be sure to submit a note or record(s) from your doctor if you had a successful kidney transplant and/or you don't need dialysis.
2. If you have other prescription drug coverage, please provide the details of your other prescription coverage in the space provided.
3. Write the name of the facility, its address, and its contact number in the spaces provided if you reside in a long-term care facility.
4. Write your Medicaid Client Identification Number (CIN) if you receive Medicaid.
5. Indicate whether or not you are, or your spouse is, currently employed.

Section 3 | Preferred Material Language and Accessible Format (where available)

- We want to make sure your plan materials are easy to read and in a language you understand. Please select your preferred language and/or format.

Section 4 | Original Medicare Insurance Information

- Use your red, white, and blue Medicare card to fill out this section. Please understand that to enroll in a Healthfirst Medicare Advantage Plan, you must qualify for Medicare Part A and be enrolled in Medicare Part B.

Section 5 | Medicare Plan Choice (Please check one and circle the premium amount next to it)

- In this section, you will find a list of Medicare Advantage plans and the monthly premium associated with each plan. Select the plan that you'd like to enroll in.

Section 6 | Your Primary Care Provider (PCP)

- Please provide the name and contact information for your Primary Care Provider (PCP), if you have one. You can find PCP information at **www.HFDocFinder.org**. If you leave this section blank or your PCP is not in our network, we will automatically assign a PCP for you. You can change your assigned PCP at a later date if you wish.

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Section 7 | Your Plan Premium

- Select your preferred premium payment method (if your plan has a monthly premium). You can choose to receive the statement each month and send us your payment by check, set up automatic deductions to have the premium deducted from your monthly Social Security or Railroad Retirement Board (RRB) benefit check, or pay online using your checking/savings account or credit/debit card. If you do not select a payment option, you will automatically receive your statement in the mail each month.
- Please note that not all Healthfirst Medicare Plans will have a plan premium.

Section 8 | Read and Sign

- It's important to read and understand the information in this section before signing and dating the form. Please understand that by signing this form, enrollment into a Healthfirst Medicare Advantage Plan will automatically end your enrollment in another Medicare health plan or prescription drug plan.

Please send the completed form and any relevant documentation by mail to:	**Healthfirst Medicare Plan** **P.O. Box 5193, New York NY 10274-5193**

If you have any questions about enrollment or eligibility, or need help with filling out this form, please contact us at **1-877-237-1303** (TTY 1-888-542-3821), Monday to Sunday, 8am–8pm. We'll make an appointment with a Marketing Representative, who can help you understand and find the right Medicare Advantage plan based on your needs.

Healthfirst Health Plan, Inc. offers HMO plans that contract with the Federal Government.
Enrollment in Healthfirst Medicare Plan depends on contract renewal.

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Enrollment Request Form

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

Section 1 Prospect Information

Last Name	First Name	M.I.	❑ Mr. ❑ Mrs. ❑ Ms.	Gender ❑ M ❑ F	Date of Birth / / MM/DD/YYYY
Permanent Residence Street Address (P.O. Box Not Allowed)			City	State	Zip Code
Mailing Address (only if different from permanent residence)			City	State	Zip Code
Home Phone (Area Code & Number) ( )	Cell Phone (Area Code & Number) ( )			Email Address (Optional)	
Emergency Contact Name	Phone (Area Code & Number) ( )			Relationship To Enrollee	

Section 2 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. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State Pharmaceutical Assistance Programs. Will you have other prescription drug coverage in addition to Healthfirst Medicare Plan? ❑ Yes ❑ No

   If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage: ____________________

   ID # for this coverage: ____________________ Group # for this coverage: ____________________

   Coverage start date: ____________________ Coverage end date (if applicable): ____________________

3. 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: ____________________

   Phone Number: ____________________

4. Are you enrolled in your State Medicaid program? ❑ Yes ❑ No

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

5. Do you or your spouse work? ❑ Yes ❑ No

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Section 3 Preferred Material Language and Accessible Format (where available)

❑ English ❑ Spanish ❑ Chinese ❑ Braille ❑ Large Print

Please contact Healthfirst Medicare Plan at 1-888-260-1010 if you need information in an accessible format or language other than those listed above. Our office hours are 7 days a week, 8am–8pm. TTY users should call 1-888-542-3821.

Section 4 Original Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white, and blue Medicare card, OR
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

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

Name of Beneficiary ______________________ Gender __________

Medicare Number ☐☐☐ ☐☐ ☐☐☐☐ ☐ ☐

IS ENTITLED TO

Hospital (Part A) ______________ **EFFECTIVE DATE** ☐☐ ☐☐ ☐☐ ☐☐

Medical (Part B) ______________ **EFFECTIVE DATE** ☐☐ ☐☐ ☐☐ ☐☐

Section 5 Medicare Plan Choice (Please check one and circle the premium amount next to it)

❑ 65 Plus Plan (HMO) [ID# 001—$0.00]

❑ Increased Benefits Plan (HMO) [ID# 019—$39.30*]

❑ Coordinated Benefits Plan (HMO) [ID# 027—$0.00]

❑ CompleteCare (HMO SNP) [ID# 034—$39.30*]

❑ Life Improvement Plan (HMO SNP) [ID# 021—$39.30*]

*The premium amount may be reduced or waived if you are receiving Low Income Subsidy or Extra Help.

Section 6 Your Primary Care Provider (PCP)

Primary Care Provider Name: ______________________

Primary Care Provider Phone Number: ______________________

Primary Care Provider Identification Number: ______________________

- **Release of information:** By joining this Medicare Health 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. This consent covers me and any of my family members for whom I may legally provide consent. 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. 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. 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.

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 each month.

You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB.

DO NOT pay Healthfirst Medicare Plan the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. If you don't select a payment option, you will get a statement each month.

Please select a premium payment option:

- ☐ Receive a statement and pay by check, made out to Healthfirst Health Plan, Inc.
- ☐ 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. Visit www.healthfirst.org/medicare and click on "Pay Your Bill" online, under "Info For Members."

Please read this important information:

If you currently have health coverage from an employer or union, joining Healthfirst Medicare Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Healthfirst Medicare Plan. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Section 8	Read and Sign

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

Healthfirst Health Plan, Inc., offers HMO plans that contract with the Federal Government. Healthfirst Medicare Plan has a contract with New York State Medicaid for Healthfirst CompleteCare (HMO SNP) and a Coordination of Benefits Agreement with the New York State Department of Health for the Healthfirst Life Improvement Plan (HMO SNP). Enrollment in Healthfirst Medicare Plan depends on contract renewal. Healthfirst Medicare Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. I will need to keep my Medicare Parts A and B. I can be in only 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 or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.

I understand that if don't have Medicare prescription drug coverage, or other 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 year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (example: October 15–December 7 of every year), or under certain special circumstances.

Healthfirst Medicare Plan serves a specific service area. If I move out of the area that Healthfirst 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 Healthfirst 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 Healthfirst Medicare Plan when I get it to know which rules I must follow to get 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 Healthfirst Medicare Plan coverage begins, I must get all of my healthcare from Healthfirst Medicare Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Healthfirst Medicare Plan and other services contained in my Healthfirst Medicare Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTHFIRST 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 Healthfirst Medicare Plan, he/she may be paid based on my enrollment in Healthfirst Medicare Plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) 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 form and 2) documentation of this authority is available upon request from 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: ____________________ Phone #: (_____) __________ Relationship to Enrollee: ______

Address: ____

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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:____________

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