VirginiaPremier™

INSTRUCTIONS for COMPLETING

Virginia Premier Advantage Elite (HMO D-SNP) Enrollment Request Form

IMPORTANT: Please **PRINT** information in pen and **DO NOT SKIP** any steps. Fill all information in as completely as possible.

Virginia Premier Advantage Elite (HMO D-SNP)

1. Review the checkbox giving consent to Virginia Premier and its representatives contacting you at any phone number you have provided, which may include mobile phone numbers.
2. Complete all of the required personal information.

   Helpful Hints:

   "Email Address" allows us to contact you electronically.

   "Mailing Address" means a street address where you receive your mail. Complete only if it is different from your Permanent Residence Address.

   "Emergency Contact Name" means the person we should notify in an emergency.

Please Provide Your Medicare Insurance Information section:

Copy this information from your red, white, and blue Medicare card.

Please Read and Answer These Important Questions section:

Complete these medical and prescription drug coverage questions. Answer Yes or No to each question and provide additional information as instructed.

STOP Please Read The Important Information and Sign Below section:

This section applies if you are enrolling in a Medicare Advantage Prescription Drug plan.

SIGN and DATE the application. You must use the current date. If you are a Legal Representative completing the form on behalf of the Medicare beneficiary, complete the Legal Representative section and attach the Power of Attorney or other document that supports your status as Legal Representative.

Eligibility Attestation for Enrollment section:

Complete this section based on your reason for enrolling in Virginia Premier.

Continued on reverse side …

… Continued from front page

TEAR OUT and MAIL ALL PAGES of the Enrollment Form:

Mail your form using the pre-paid envelope in your enrollment kit or send to:

Virginia Premier Medicare Advantage
Attn: Enrollment
PO Box 104921
Jefferson City, MO 65110-9807

Enrollment Request Form Receipt:

Please complete the Medicare Advantage Enrollment Receipt on the last page of this enrollment booklet. Be sure to tear out this receipt and keep it for your records as proof of your enrollment request.

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INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

Who can use this form?

People with Medicare who want to join a Medicare Advantage 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 January 1)
- 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:

Virginia Premier
PO Box 104921
Jefferson City, MO 65110-9807

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

How do I get help with this form?

Call Virginia Premier at 1-833-280-1194. TTY users can call 711.

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

En español: Llame a Virginia Premier al 1-833-280-1194 (TTY: 711) 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.

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Please contact Virginia Premier if you need information in another language or format (Braille)

This Plan Requires Individuals to Have Both Medicare and Medicaid Coverage.
To Enroll in Virginia Premier Advantage Elite (HMO D-SNP), Please Provide the Following Information:

LAST Name: FIRST Name: Middle Initial: ☐ Mr. ☐ Ms. ☐ Mrs.

Birth Date: ___/___/____ (MM/DD/YYYY) | Sex: ☐ M ☐ F | Home Phone Number: ( ) | *Optional field:* Alternate Phone Number: ( )

☐ By checking this box, you are consenting to Virginia Premier and its representatives contacting you at any phone number you have provided to us, which may include mobile phone numbers. You understand that you are not required to agree, and agreeing is not a condition of being an Virginia Premier member or receiving health care. Communications directed to these phone numbers may be carried out using automated dialing/delivery devices, direct dial, text message, SMS (short message service) or RCS (rich communication services) messages, ringless voicemail, and prerecorded or artificial voices. Communications may include, but may not be limited to, information regarding medication, wellness, preventive care, communication preferences, and payment. Communications and their content, which may include health information, will not be encrypted. You may revoke this consent at any time. To opt out of phone calls, call 1-833-280-1194. To opt out of text messages, text STOP to short code 59270 or call 1-833-280-1194. If you are not the subscriber to the phone number you provided, then you agree that you have obtained the subscriber's consent to receive these communications. Virginia Premier will not charge you for these communications. Carrier message and data rates may apply.

Email Address: _____

☐ I give Virginia Premier permission to send my plan materials and member communications, excluding Explanation of Benefits (EOBs), by email.

Permanent Residence Street Address (P. O. Box is not allowed):

Street Address: _____

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

Mailing Address (only if different from your Permanent Residence Address):

Street Address: _____

City: State: ZIP Code:

Optional field: **Emergency contact:** _____

Phone Number: **Relationship to You:**

Please Provide Your Medicare Insurance Information

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): _____ PRINT NAME

_____ SIGNATURE

Medicare Number: _____

Is Entitled to: Effective Dates:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

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

Please read and answer these important questions:

1. 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 Virginia Premier? ☐ 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 _____

2. 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 of Institution (number and street): _____

_____

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

If yes, please provide your Medicaid number: _____

4. **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, Puerto Rican
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Cuban
☐ **I choose not to answer.**

What's your race? Select all that apply.

☐ American Indian or Alaska Native
☐ Chinese
☐ Japanese
☐ Other Asian
☐ Vietnamese
☐ Asian Indian Filipino
☐ Korean
☐ Other Pacific Islander
☐ White
☐ Black or African American
☐ Guamanian or Chamorro
☐ Native Hawaiian
☐ Samoan
☐ **I choose not to answer.**

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

Optional field: **Please choose the name of a Primary Care Physician (PCP), clinic or health center:**

Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

☐ Spanish ☐ Large print

Please contact Virginia Premier at 1-833-280-1194 if you need information in an accessible format or language other than what is listed above. Our office hours are 8 am to 8 pm, 7 days a week from October 1 to March 31. From April 1 through September 30, we are open Monday through Friday, 8 am to 8 pm. On certain holidays and weekends from April 1 through September 30, your call will be handled by our automated phone system. TTY users should call 711.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Virginia Premier could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Virginia Premier. 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.

Please Read and Sign Below

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

Virginia Premier 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 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. 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.

Virginia Premier serves a specific service area. If I move out of the area that Virginia Premier 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 Virginia Premier, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Virginia Premier 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 Virginia Premier coverage begins, I must get all of my health care from Virginia Premier, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Virginia Premier and other services contained in my Virginia Premier Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR VIRGINIA PREMIER 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 Virginia Premier, he/she may be paid based on my enrollment in Virginia Premier.

Release of Information: By joining this Medicare health plan, I acknowledge that Virginia Premier will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Virginia Premier 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 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 and 2) documentation of this authority is available upon request from Medicare.

Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

Phone Number: ( ) _____

Relationship to Enrollee: _____

Applicant: Please do not complete the following sections
Agent/Broker: Please fill in ALL fields below

Coverage effective date: _____ PLAN ID #: H9877_001

☐ IEP/ICEP ☐ AEP ☐ OEP ☐ SEP(type): _____ ☐ Not eligible

I helped the applicant fill out this application. ☐ Yes ☐ No

Was this an individual face-to-face appointment? ☐ Yes ☐ No

If yes, how was a scope of appointment (SOA) collected?

☐ Paper ☐ Recorded call Date recorded _____ Time recorded _____ EST. AM/PM

Print Name: _____ _____
FIRST LAST

Writing Agent Producer Number (P-Number): _____

Phone: _____ Fax: _____

Email: _____

Signature: _____ Application received date: _____

Attestation of Eligibility for an Enrollment Period

Referenced in section: 30.4

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Annual Enrollment Period (AEP), October 15 through December 7.
- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (OEP), January 1 through March 31.
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.
- ☐ I recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ☐ I recently had a change in my *Extra Help* paying for Medicare prescription drug coverage (newly got *Extra Help*, had a change in the level of *Extra Help*, or lost *Extra Help*) on (insert date) _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get *Extra Help* paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I recently left a PACE program on (insert date) _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ☐ I am leaving employer or union coverage on (insert date) _____.
- ☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____ .

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact Virginia Premier at 1-833-280-1194 (TTY users should call 711) to see if you are eligible to enroll. We are open 8 am to 8 pm, 7 days a week from October 1 to March 31. From April 1 through September 30, we are open Monday through Friday, 8 am to 8 pm.

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Medicare Advantage Enrollment Receipt

Please keep this receipt as proof of your enrollment request until Medicare has confirmed your official enrollment in our plan and you have received your member materials. The receipt is not a guarantee of enrollment as the Centers for Medicaid & Medicare Services must still approve your official enrollment request.

This receipt is for your records only.

Applicant:

Name: _____

Today's date: _____ Proposed Effective Date: _____

Agent/Broker or Medicare Sales Representative:

Name:_____ Phone Number:_____

If you would like a complete copy of your enrollment form please call Member Services toll free at 1-877-739-1370 (TYY: 711).

October 1–March 31 | 7 days a week | 8 a.m.–8 p.m.
April 1–September 30 | Monday–Friday | 8 a.m.–8 p.m.

On certain holidays your call will be handled by our automated phone system.

Please allow at least 5 business days to process your application, you'll need to provide the application tracking number at the bottom of this page when you call Member Services.

Applicant Signature: _____

Please see the Pre-Enrollment Checklist before you apply for our plan. Also if you would like a Sales Representative to meet with you, please complete the Scope of Appointment form and check the products that you would like the representative to discuss with you.

Visit our website by scanning this code with your smartphone camera or QR Code reader app.

Virginia Premier Advantage Elite (HMO D-SNP) is a Coordinated Care Plan with a Medicare contract and a contract with the Virginia Medicaid Program. Enrollment in Virginia Premier Advantage Elite depends on contract renewal.