West Virginia Senior Advantage

OMB No. 0938-1373 Expires 02/28/2029

Exhibit 1: Model Individual Enrollment Request form to enroll in a Medicare Advantage Plan (Part C) or Medicare Prescription Drug Plan (Part D)

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)

Important: To join a Medicare Prescription Drug Plan, you must also have either, or 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.

- 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:

West Virginia Senior Advantage
PO Box 3630
Little Rock, AR 72202

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

How do I get help with this form?

Call West Virginia Senior Advantage at (866) 250-6352. TTY/TDD users can call 711.

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

En español: Llame a West Virginia Senior Advantage, al (866) 250-6352, (TTY/TDD 711) 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.

Reminders:

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

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

Select the plan you want to join:
☐ ISNP

FIRST Name:	LAST Name:	Optional: Middle Initial:

Birth Date: (MM/DD/YYYY) (/ /)	Sex: ☐ Male ☐ Female	Phone number: ( )

Permanent Residence street address (Don't enter a PO Box. NOTE: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address):

City:	Optional: County:	State:	Zip Code:

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

Your Medicare information:

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

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE, pension plans) in addition to West Virginia Senior Advantage? ☐ Yes ☐ No

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

Are you enrolled in your State Medicaid program? ☐ Yes ☐ No
If yes: Medicaid Number: _____

Have you been a resident in or expect to reside in a long-term care facility, such as a nursing home, in the West Virginia Senior Advantage network for more than 90 days? ☐ Yes ☐ No

Name of Facility: _____ Admission Date: _____

IMPORTANT: Read and sign below

• I must keep both Hospital (Part A) and Medical (Part B) to stay in West Virginia Senior Advantage's plan.
• By joining this Medicare Advantage Plan, I acknowledge that West Virginia Senior Advantage 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 or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
• I understand that when my West Virginia Senior Advantage coverage begins, I must get all of my medical and prescription drug benefits from West Virginia Senior Advantage. Benefits and services provided by West Virginia Senior Advantage and contained in my West Virginia Senior Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor West Virginia Senior Advantage 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.

Let us know if you want us to send you information in a language other than English.

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact West Virginia Senior Advantage at (866) 250-6352 if you need information in an accessible format other than what's listed above. Our office hours are 8:00 a.m. to 8:00 p.m. Eastern, seven days a week, October 1 through March 31 (8:00 a.m. to 8:00 p.m. Eastern, Monday through Friday, April 1 through September 30). TTY/TDD 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:

I want to get the following materials via email. Select one or more:

☐ Provider Directory ☐ Pharmacy Directory ☐ Formulary ☐ Summary of Benefits
☐ Evidence of Coverage ☐ Nondiscrimination Notice ☐ Notice of Privacy Practices

Email address:

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mailing a 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.**

If you don't select a payment option, you will get a bill each month. Please select a premium payment option:

☐ Get a bill

☐ No Premium (Dually Eligible)

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

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 West Virginia Senior Advantage the Part D-IRMAA.

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e., agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name:_____ **Relationship to Enrollee:**_____

Signature:_____

National Producer Number (Agents/Brokers only):_____

For Health Plan Use Only

Agent Name:_____ Agent NPI ID:_____

Receipt Date of Application:_____Proposed Effective Date:_____

☐ICEP/IEP ☐AEP ☐OEPI ☐SEP (Type)_____ ☐Not Eligible

Sales Agent Signature Attestation:

I do hereby attest that the information within this application is true and accurate to the best of my knowledge and that I witnessed the above-signed enrollee sign the enrollment application.

_____ _____

Sales Agent Signature Date

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.