OMB No. 0938-1378
Expires: 12/31/2026

AmeriHealth Caritas VIP Care

Individual Enrollment Request Form

Please contact AmeriHealth Caritas VIP Care if you need information in another language or format (for example, braille).

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 United States. • 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 three months of first getting Medicare • In certain situations where you're allowed to join or switch plans Visit **www.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: AmeriHealth Caritas VIP Care P.O. Box 7137 London, KY 40742-9732 Once they process your request to join, they'll contact you.
How do I get help with this form?	Call AmeriHealth Caritas VIP Care at **1-855-241-3648**. 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 AmeriHealth Caritas VIP Care al **1-855-241-3648**/**711** (TTY) o a Medicare gratis al **1-800-633-4227** y oprima el 8 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.

SECTION 1 — ALL FIELDS ON THIS PAGE ARE REQUIRED (UNLESS MARKED OPTIONAL).

SELECT THE PLAN YOU WANT TO JOIN:

☐ AmeriHealth Caritas VIP Care (HMO-SNP) (PA02) — $0 per month

Last name:	First name:	Middle initial (optional):	☐ Mr. ☐ Mrs. ☐ Ms.
Birth date: (MM/DD/YYYY)		Sex: ☐ M ☐ F	
Phone number:			
Permanent residence street address (Don't enter a P.O. Box. Note: For individuals experiencing homelessness, a P.O. Box may be considered your permanent residence address.):			
City:			
County (optional):		State:	ZIP code:

MAILING ADDRESS (IF DIFFERENT FROM YOUR PERMANENT ADDRESS) (P.O. 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) in addition to AmeriHealth Caritas VIP Care?

☐ **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," please provide your Medicaid number:

IMPORTANT: READ AND SIGN BELOW

- I must keep both hospital (Part A) and medical (Part B) to stay in AmeriHealth Caritas VIP Care.
- By joining this Medicare Advantage (MA) plan, I acknowledge that AmeriHealth Caritas VIP Care 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 AmeriHealth Caritas VIP Care coverage begins, I must get all of my medical and prescription drug benefits from AmeriHealth Caritas VIP Care. Benefits and services provided by AmeriHealth Caritas VIP Care and contained in my AmeriHealth Caritas VIP Care "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor AmeriHealth Caritas VIP Care 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.

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact AmeriHealth Caritas VIP Care at **1-855-241-3648** if you need information in an accessible format other than what's listed above. Our office hours are October 1 – March 31: 8 a.m. – 8 p.m., seven days a week; April 1 – September 30: 8 a.m. – 8 p.m., Monday through Friday. TTY 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 am a current patient of this provider.

Email address:

I want to get the following materials via email (select one or more):

Communications related to:

☐ Health education ☐ Health reminders

☐ Other information (please specify):

For individuals helping enrollees 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:

Signature:

Relationship to enrollee:

National Producer Number (Agents/Brokers only):

Office use only:			
Name of staff member, agent, or broker (if assisted in enrollment):			
Plan ID number: 001		Effective date of coverage:	
Application date:			
☐ ICEP/IEP	☐ AEP	☐ SEP	☐ MA OEP
Not eligible:	Other:		
NIPR number:	Agent ID:	Agent writing number:	
Agent signature:			

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.

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Typically, you may enroll in a Medicare Prescription Drug 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 Prescription Drug 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.

New to Medicare or a Change to Your Coverage

☐ I am making my annual enrollment election (October 15 – December 7).

☐ I am new to Medicare.

☐ I recently involuntarily lost my creditable prescription coverage ("creditable" means coverage as good as Medicare's). I lost my drug coverage on _____ (insert date).

☐ I am leaving or have left employer or union coverage on _____ (insert date).

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

☐ In the last 12 months, I left a Medigap policy to join a Medicare Advantage Plan* for the first time (*Medicare Advantage plan with prescription drug coverage).

☐ I have been on Medicare but just turned 65 or will be turning 65 in the next three months.

☐ My current plan was placed into Receivership by CMS due to financial difficulties.

☐ I am within the 4th to 7th month of my initial election period.

Recent Change in Residence

☐ I recently moved or plan to move outside of the service area for my current plan, or I recently moved or plan to move and this plan is a new option for me _____ (insert move date).

☐ I recently returned to the U.S. after living permanently outside of the U.S. I returned to the U.S. on _____ (insert date).

☐ I am moving into, live in, or recently moved out of a Long-Term Care facility (for example, a nursing home).

☐ I moved/will move into/out of the facility on _____ (insert date).

☐ I recently obtained lawful presence status in the U.S. I got this status on _____ (insert date).

☐ I recently was released from incarceration. I was released on _____ (insert date).

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Change in Income or Special Needs/Plan Qualifications

- ☐ I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP).
- ☐ 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 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 belong to a pharmacy assistance program provided by my state.
- ☐ I recently left a PACE plan (Program of All-Inclusive Care for the Elderly) 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 am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ 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 recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, lost Medicaid) on _____ (insert date).
- ☐ This is my first time for Part B Entitlement.

Other Reason

- ☐ I am in a plan that is identified as a consistent poor performer.
- ☐ I am enrolling in a 5-Star Medicare plan.
- ☐ None of the above apply.

If none of these statements applies to you or you're not sure, please contact AmeriHealth Caritas VIP Care at **1-855-241-3648 (TTY 711)** to see if you are eligible to enroll. We are open October 1 – March 31: 8 a.m. – 8 p.m., seven days a week, and April 1 – September 30: 8 a.m. – 8 p.m., Monday through Friday.

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 and 1860D-1 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.