COMMUNITY HEALTH PLAN of Washington™

The power of community

MEDICARE ADVANTAGE

Plan Change Form

1111 3rd Ave, Ste 400, Seattle WA 98101 | 1-800-944-1247 (TTY Relay: Dial 711) | Fax 206-613-5089

H5826_MK211_PlanChangeForm_09_2023_C CMS Approved 09/26/2022

Please contact Community Health Plan of Washington (CHPW) if you need information in another language or format (Braille or large print).

To Enroll in CHPW Medicare Advantage (MA), please provide the following information

Please check which plan you want to enroll in: 2023 Monthly Premiums:

- ☐ **CHPW MA Plan 1 (HMO)..... $0.00 per month**
- ☐ **CHPW MA Plan 2 (HMO)..... $41.00 per month**
- ☐ **CHPW MA Plan 3 (HMO)..... $70.00 per month**
- ☐ **CHPW MA Plan 4 (HMO)..... $102.00 per month**
- ☐ **CHPW MA Freedom Plan (HMO)..... $0.00 per month**
- ☐ **CHPW MA Dual Plan (HMO SNP)..... $0.00 per month***

** Premium rate is based upon level of State Medicaid eligibility.*

Name of chosen Primary Care Physician (PCP), clinic or health center *(optional)***:**

Last Name, First Name, Middle Initial:	Member Number:	Date of Birth:

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

City, State:	County:	ZIP Code:	Home Phone Number:

Mailing Address *(only if different from your Permanent Residence Street Address)*

Street Address: City/State: ZIP Code:

Please fill out the following:

I am currently a member of the _____ plan in CHPW Medicare Advantage with a monthly premium of $ _____.

I would like to change to the _____ plan in CHPW Medicare Advantage with a monthly premium of $ _____.

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

☐ **Spanish** ☐ **Braille** ☐ **Large Print**

Please contact us at 1-800-942-0247 if you need information in an accessible format or language other than what is listed above. Our office hours are 8:00 a.m. - 8:00 p.m., 7 days a week. TTY users should call 711.

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 Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security, credit card, 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 RRB. DO NOT pay Community Health Plan of Washington (CHPW) Medicare Advantage (MA) the Part D-IRMAA.

People with limited income 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 **socialsecurity.gov/prescriptionhelp**.

If you qualify for extra help with your Medicare prescription drug coverage 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 bill each month.

Please select a premium payment option:

☐ **Get a bill and pay by personal check on a monthly basis**.

☐ **Electronic Funds Transfer (EFT) from your bank account each month**
Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: _____ Bank account number: _____

Account type: ☐ **Checking** ☐ **Savings**

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

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

(The Social Security deduction may take two or more months to begin after Social Security or RRB approves the 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 bill for your monthly premiums.)

☐ **Pay online using your credit or debit card**. I will pay my monthly plan premium directly by using E-Bill Express, an online payment tool. Once I am a member, I will sign up on E-Bill Express to make single payments or set up automatic recurring payments from my credit or debit card. For more information or to enroll in this payment option, visit our website at: **medicare.chpw.org/member-center/member-self-service/pay-your-bills/**.

STOP! Please Read This Important Information and Sign Below

Community Health Plan of Washington (CHPW) Medicare Advantage 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 CHPW, he/she may be paid based on my enrollment in CHPW Medicare Advantage plan.

Release of Information:
By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Community Health Plan of Washington Medicare Advantage will release my information 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 people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date CHPW Medicare Advantage coverage begins, I must get all of my health care from them, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by CHPW Medicare Advantage and other services in my plan's Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR CHPW MEDICARE ADVANTAGE WILL PAY FOR THESE SERVICES.

I understand that my signature (or 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 plan. 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 provide the following information:

Name:_____ Address: _____

Phone Number: _____ Relationship to Enrollee:_____

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment):	Agent ID#:

Date Received: _____ Effective Date: _____

ICEP/IEP _____ AEP _____ SEP (type) _____ Not Eligible _____

ProviderOne #: _____