COMMUNITY HEALTH PLAN of Washington™
MEDICARE ADVANTAGE

Individual Enrollment Form

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 15th–December 7th each year (for coverage starting January 1st)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Call us or 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 our plan during the Annual Enrollment Period (October 15–December 7), we must get your completed form by December 7.
- We 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:

Community Health Plan of Washington
Medicare Advantage
1111 3rd Ave, Ste 400
Seattle, WA 98101

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

How do I get help with this form?

Call Community Health Plan of Washington Medicare Advantage at 1-800-944-1247. 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 Community Health Plan of Washington Medicare Advantage al 1-800-944-1247/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.

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

Select the plan you want to enroll in:

- ☐ **CHPW Dual Complete (HMO D-SNP)** $0.00*/month
- ☐ **CHPW Dual Select (HMO D-SNP)**.. $0-$26.20*/month
- ☐ **CHPW MA Plan 2 (HMO)**..... $23.10/month
- ☐ **CHPW MA Plan 4 (HMO)**.....$107.00/month
- ☐ **CHPW MA Freedom Plan (HMO)** $0.00/month

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

Last Name:	First Name:	Middle Initial:

Birth Date *(MM/DD/YYYY)*:

Sex: M ☐ F ☐ Other ☐

Phone Number:

Permanent Residence Street Address *(Don't enter a P.O. Box)*:

City:	County:	State:	ZIP Code:

Mailing Address *(If different from your permanent address, P.O. Box allowed)*:

City:	County:	State:	ZIP Code:

Cell Phone: *(Optional)***	Email Address: *(Optional)***

***By providing email address and cell phone number, you agree to opt-in to text and email communications from Community Health Plan of Washington.*

☐ Yes, I would like to receive my Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) digitally

Your Medicare Information:

Medicare Number:

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to CHPW Medicare Advantage? ☐ Yes ☐ No

Name of other coverage:

Member number for this coverage:

Group number for this coverage:

Are you dual eligible through Medicaid (Status QMB, SLMB, CNP, etc.)? ☐ Yes ☐ No

ProviderOne Number *(Medicaid Members Only)*:

List your Primary Care Physician (PCP), clinic, or health center:

IMPORTANT - Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Community Health Plan of Washington (CHPW) Medicare Advantage (MA).
- By joining this Medicare Advantage Plan, I acknowledge that CHPW MA 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).
- 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 when my CHPW MA coverage begins, I must get all of my medical and prescription drug benefits from CHPW MA. Benefits and services provided by CHPW MA and contained in my CHPW MA "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CHPW MA will pay for benefits or services that are not covered.
- 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 *(MM/DD/YYYY)*:

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: _____ Signature: _____

Relationship to enrollee: _____ National Producer Number (Agents/Brokers only): _____

PLAN USE ONLY: ☐ ICEP/IEP ☐ AEP ☐ MA OEP ☐ SEP (List Type) _____ ☐ Not Eligible				
Agent Number	Referral Code	Date Received	Date Entered	Proposed Effective Date

Section 2 – All fields in this section are optional

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

What is your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____
- ☐ I choose not to answer

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ I don't know
- ☐ I choose not to answer

Select one if you want us to send you information in a language other than English ☐ **Spanish**

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

☐ **Braille** ☐ **Large print**

Please contact Community Health Plan of Washington Medicare Advantage at 1-800-942-0247 if you need information in an accessible format other than what's listed above. Our office hours are 8:00 a.m. - 8:00 p.m., seven days a week. TTY users can call 711.

Do you or your spouse work? ☐ Yes ☐ No

☐ Preferred Spoken Language _____

PRIVACY STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

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 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.

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 automatic deduction may take two or more months to begin after Social Security or RRB approves it. 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