

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

Who can use this form?

People who qualify to receive Medicare who want to join a Medicare Advantage Plan.

To qualify for 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 use this form to join a plan:

- Between October 15 to 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 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, if there is one. 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 after you complete this form?

Send your completed and signed form to:

Sentara Medicare
P.O. Box 106145
Jefferson City, MO 65110-9806

Once we process your request to join, you will be contacted.

How do I get help with this form?

Call Sentara Medicare at **1-888-460-8129 (TTY: 711)**.

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

En español: Llame a Sentara Medicare al **1-855-687-6260 (TTY: 711)** 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.

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 Reports Clearance Officer
Mail Stop C4-26-05, Baltimore
Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens after you complete this form?" on the previous page to send your completed form to the plan.



2027 Sentara Medicare enrollment request form

Contact Sentara Medicare at **1-888-460-8129 (TTY: 711)** if you need information in another format or language. We are available October 1-March 31, 7 days a week, 8 a.m.-8 p.m. and April 1-September 30, Monday-Friday, 8 a.m.-6 p.m.

Section 1 - This plan requires individuals to have both Medicare and Medicaid coverage. To enroll in Sentara Medicare , please provide the following required information:

Name of the plan you are enrolling in: ☒ Sentara Community Complete Select \$0 premium per month		Effective Date Requested:	
☐ Mr. ☐ Mrs. ☐ Ms.		FIRST name:	Middle initial: LAST name:
Birth date:	Sex: ☐ M ☐ F	Home phone number: Mobile phone number:	
☐ By checking this box, you are consenting to Sentara Medicare 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 a Sentara Medicare member or receiving healthcare. 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 1-888-460-8129 from October 1-March 31, 7 days a week, 8 a.m.-8 p.m. and April 1-September 30, Monday-Friday, 8 a.m.-6 p.m. To opt out of text messages, text STOP to short code 59270 or call 1-888-460-8129. If you are not the subscriber to the phone number you provided, then you agree you have obtained the subscriber's consent to receive these communications. Sentara Medicare will not charge you for these communications. Carrier message and data rates may apply.			
Email address:			
☐ I give Sentara Medicare permission to send my plan materials and member communications by email.			
Permanent residence street address: (P.O. Box is not allowed)			Apt. #
City or county:		State: VA	ZIP code:
Mailing address - Street address/P.O. Box: (only if different from your permanent residence address):			Apt. #
City or county:		State:	ZIP code:
Emergency contact name:		Relationship to you:	
Emergency contact phone number:			
Please select a primary care physician from our 2027 Provider Directory:			

Section 2 - 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.

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

Name (as it appears on your Medicare card):

Medicare number:

Is entitled to:

Effective date:

Hospital (Part A)

Medical (Part B)

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

Section 3 - Please provide your Medicaid insurance information

Medicaid number:

Section 4 - Paying your plan premium and/or late enrollment penalty (LEP):

If we determine you owe a late enrollment penalty (LEP), or if you currently have a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail, electronic funds transfer (EFT) each month, or by automatic deduction from your monthly Social Security benefit or Railroad Retirement Board (RRB) benefit check. If you are assessed a Part D-income related monthly adjustment amount (Part D-IRMAA), 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 the RRB. DO NOT pay Sentara Medicare .

Please provide any non-Medicare pharmacy plan information for drug coverage you have had since becoming eligible for Medicare Part D benefits to determine whether you may be charged a LEP.

Plan name	Policy number	Beginning/ending date
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Please select a premium payment or LEP option:

If you have a premium payment or LEP and do not select a payment option, you will receive a bill each month.

- ☐ Receive a monthly bill
- ☐ Electronic funds transfer (EFT) from your bank checking or savings account each month. Please enclose a VOIDED check or deposit slip, and provide the following in order for your auto deduction to be processed:

Account holder name:

Bank routing number:

Bank account number:

- ☐ Automatic deduction from your monthly Social Security or Railroad Retirement Benefit (RRB) benefit check. The Social Security/RRB deduction may take a few months to begin. Typically, if Social Security/RRB approves the automatic deduction, the first deduction will include all premiums due from the time withholding begins. Please be aware, if the withholding does not start at time of enrollment, you will be responsible for payment until withholding begins. You will receive a bill.

I get monthly benefits from: ☐ Social Security ☐ RRB

Section 5 - Please read and answer these important questions:

1. Do you have other health insurance? ☐ Yes ☐ No

2. Do you currently have any other medical coverage, including other **private insurance, VA benefits, Medicaid, TRICARE, or Federal Employee Health Benefits** coverage? ☐ 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:	Ending coverage date:
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Will you have any other **prescription drug coverage** in addition to Sentara Medicare? ☐ 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:	Ending coverage date:
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Section 5 - Continued:

Attestation of eligibility for an enrollment period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 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, to the best of your knowledge, you are eligible for an enrollment period.

If we later determine 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).
- ☐ 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).
- ☐ I recently moved outside of the service area for my current plan, or I recently moved and have new options available to 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 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'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ☐ 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 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.

Section 5 - Continued:

- ☐ 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.
- ☐ I am not institutionalized in a State or private ICF/ID and State ICF/MH facilities.
- ☐ I do not reside a State facility operated by DBHDS (Virginia Department of Behavioral Health and Developmental Services).
- ☐ I do not reside in nursing facilities operated by the U.S. Department of Veterans Affairs, the Virginia Home Nursing Facility, local government-owned nursing homes, and individuals authorized by the Department to receive care/treatment in facilities located outside of Virginia.
- ☐ Other:

If none of these statements applies to you or you're not sure, please contact Sentara Medicare at **1-888-460-8129 (TTY: 711)** to see if you are eligible to enroll. We are open October 1-March 31, 7 days a week, 8 a.m.-8 p.m. and April 1-September 30, Monday-Friday, 8 a.m.-6 p.m.



Please read the important information in section 6 and sign below.

If you currently have health coverage from an employer or union, joining a Medicare Advantage Prescription Drug Plan with Sentara Medicare could affect your ability to keep your employer or union health coverage. You could lose your employer or union health coverage if you join Sentara Community Complete Select. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

I understand my signature (or the signature of the legal representative authorized to act on my behalf under the laws of the state where I live) on this application means I have read and understand the contents of this application, including the agreement on page 6. If signed by an authorized individual (as described above), this signature certifies 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request by Sentara Medicare or by Medicare.

Signature:

Today's date:

Legal representative – sign above and provide information below:

Name:

Address:

Phone number:

Relationship to enrollee:

Agent use only:

Agent name (please print):

Agent NPN# :

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 ☐ Braille ☐ Audio CD ☐ Data CD

Contact Sentara Medicare at **1-888-460-8129 (TTY: 711)** if you need information in an accessible format or language other than what is listed above. We are available October 1-March 31, 7 days a week, 8 a.m.-8 p.m. and April 1-September 30, Monday-Friday, 8 a.m.-6 p.m. On certain holidays and weekends from April 1–September 30, your call will be handled by our automated phone system.

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.

Section 6 - Please read below

Sentara Medicare is an HMO Dual Eligible Special Needs Plan (HMO D-SNP) that has contracts with Medicare and the Virginia Department of Medical Assistance Services' Medicaid program. "Cardinal Care" is the brand name of Virginia Medicaid. Enrollment in Sentara Medicare depends on contract renewal.

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

I must keep both hospital (Part A) and medical (Part B) to stay in Sentara Medicare . I can be in only one Medicare Advantage plan at a time, and I understand 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 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 (For example: October 15 – December 7 of every year), or under certain special circumstances. I must continue to pay or have the State pay for my Medicare Part B premium.

Sentara Medicare serves a specific service area. If I move out of the area that Sentara Medicare serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand people with Medicare are not usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

Once I am a member of Sentara Medicare , I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Sentara Medicare when I receive it to know which rules I must follow to receive coverage with this Medicare Advantage plan. Neither Medicare nor Sentara Community Complete Select will pay for benefits or services that are not covered.

I understand beginning on the date Sentara Medicare coverage begins, I must get all of my healthcare from Sentara Medicare , except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Sentara Medicare and other services contained in my Sentara Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Except for emergency care, urgently needed services, out-of-area dialysis, and other covered exceptions described in the Evidence of Coverage, services generally must be provided or authorized under plan rules to be covered.

I understand if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Sentara Medicare , he/she may be paid based on my enrollment in Sentara Medicare .

Release of information: By joining this Medicare health plan, I acknowledge that Sentara Medicare will release my information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations. I also acknowledge that Sentara Medicare 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 if I intentionally provide false information on this form, I will be disenrolled from the plan.

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:	
☐ Agent	☐ Authorized representatives
☐ Broker	☐ Self
☐ SHIP counselors	☐ Other (third parties) _____

National Producer Number (Agents/Brokers only):

Office use only:

Plan ID #:

Effective date of coverage:

☐ ICEP/IEP ☐ AEP ☐ OEP ☐ SEP (type):