VNSNY CHOICE EasyCare (HMO) and EasyCare Plus (HMO D-SNP) Enrollment Request 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 A (Hospital Insurance)
- Medicaid

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.

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.
- If you pay a monthly premium for your Medicare prescription drug coverage 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:
VNSNY CHOICE Medicare
220 East 42nd Street, 3rd Floor,
New York, NY 10017

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

How do I get help with this form?

Call VNSNY CHOICE Medicare at 1-866-783-1444 (TTY: 711).

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

Enrollment Form

VISITING NURSE SERVICE OF NEW YORK VNSNY CHOICE Health Plans

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

☐ **VNSNY CHOICE EasyCare (HMO) ($25.00 premium per month)**

☐ **VNSNY CHOICE EasyCare Plus (HMO D-SNP) ($0* premium per month)**

*Depending on your level of Medicaid eligibility.

FIRST Name:	LAST Name:	[Optional: Middle Initial]:

Birth Date (mm/dd/yyyy):	Sex:	Phone Number:	Alternate Phone Number:
(/ /)	☐ Male ☐ Female	( )	( )

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

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:

1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to VNSNY CHOICE Medicare? ☐ Yes ☐ No

Name of other coverage: ID # for this coverage: Group # for this coverage

_____ _____ _____

2. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If "yes," please provide the following information:

Name of Institution: _____

Address & Phone Number of Institution (number and street): _____

_____

3. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If yes, please provide your Medicaid number: _____

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IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in VNSNY CHOICE Medicare.
- By joining this Medicare Advantage Plan, I acknowledge that VNSNY CHOICE Medicare 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.
- 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 are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my VNSNY CHOICE Medicare coverage begins, I must get all of my medical and prescription drug benefits from VNSNY CHOICE Medicare. Benefits and services provided by VNSNY CHOICE Medicare and contained in my VNSNY CHOICE Medicare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor VNSNY CHOICE Medicare 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.

For individuals with Medicare and Medicaid:

- I understand that I must have Medicaid to be eligible to enroll in VNSNY CHOICE EasyCare Plus.
- I understand that I can enroll or disenroll once per calendar year quarter during the first nine months of the year.
- I understand that I will not be responsible for paying a Part D Late Enrollment Penalty (LEP).

Signature:	**Today's Date:**
If you are the authorized representative, you must sign above and fill out these fields:	
Name:	Address:
Phone Number: ( )	Relationship to Enrollee:

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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 a language other than English.

☐ Spanish ☐ Chinese

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

☐ Braille ☐ Large print ☐ Audio CD

Please contact VNSNY CHOICE Medicare at 1-866-783-1444 if you need information in an accessible format other than what's listed above. We are open 7 days a week from 8 am – 8pm. (TTY: 711).

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

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

PCP Name: _____

PCP ID#: _____

I want to get Complaint (Grievance) Notices, Appeals Decisions, Referral Notices, Service Authorization Notices and Decisions via email.

☐ Yes ☐ No

E-mail 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 mail 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**.

Please select a premium payment option:

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

I get monthly benefits from: ☐ Social Security ☐ RRB

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. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay VNSNY CHOICE Medicare the Part D-IRMAA.

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.

Office Use Only: Tracking Code: _____

Name of Staff Member/Agent/Broker (if assisted in enrollment): _____

Agent Signature: _____

MGA: _____ Agent #: _____ Plan ID #: _____

Date Received in Office: _____ Received By (initials): _____ Entered By (initials): _____

Effective Date of Coverage: _____

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

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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 of 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 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.

- ☐ 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 (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for 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 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 am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). 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.
- ☐ 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 Dual Special Needs Plan (D-SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the D-SNP on (insert date) _____.
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact VNSNY CHOICE Medicare at 1-718-4CHOICE (718-424-6423) (TTY: 711) to see if you are eligible to enroll. We are open 7 days a week from 8 am – 8 pm.

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