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

Select the plan you want to join:
□ Community DualCare Access – $0 per month □ Community DualCare Aligned – $0 per month

First Name:	Last name:	Middle initial:
Birth date: (MM/DD/YYYY) (/ /)	Sex: □ Male □ Female	Phone number: ( )

Permanent Residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:	County:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):
Street address:

City:	County:	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 Community?
□ 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: _____

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 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 recently left a PACE program on (insert date) _____.

☐ 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 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 am in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.

☐ 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 because of the disaster.

☐ I qualify for a Special Election Period because _____.

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Community DualCare Aligned (HMO DSNP) or Community DualCare Access (HMO D-SNP).
- By joining this Medicare Advantage, I acknowledge Community Health Choice 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 Community DualCare Aligned (HMO D-SNP) or Community DualCare Access (HMO D-SNP) coverage begins, I must get all of my medical and prescription drug benefits from Community Health Choice. Benefits and services provided by Community DualCare Aligned (HMO D-SNP) or Community DualCare Access (HMO D-SNP) and contained in my "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Community Health Choice 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:**
Name:	Address:
Phone number:	Relationship to enrollee:

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:	Relationship to enrollee:
Signature:	Broker NPN (Agents/Brokers only):

Office Use Only

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

_____

Broker NPN:_____ **Plan ID#**:_____ **Eff. Date of Coverage**:_____

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