# 2023 CHRISTUS Health Plan
# Medicare Advantage Plan Application

**Who can use this form?**

People with Medicare who want to join a Medicare Advantage plan or Medicare Prescription Drug 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 15-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 Numbers (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.
- 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:
CHRISTUS Health Plan
919 Hidden Ridge Drive
Irving | TX 75038

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

**How do I get help with this form?**

Call CHRISTUS Health Plan Medicare Advantage Plan (HMO) at 844.282.3026. 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 CHRISTUS Health Plan Medicare Advantage Plan (HMO) al 844.282.3026, TTY 711 o a Medicare gratis al 1.800.633.4227 y oprima el 2 para asistencia an 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 where you receive mail (e.g., social security checks) may be considered your permanent residence address.

# CHRISTUS Health Plan Medicare Advantage Enrollment Application

Please check the plan that you want:

☐ CHRISTUS Health Plan Generations Plus (HMO) Plan 005 ($0 monthly premium)

☐ CHRISTUS Health Plan Guardian (HMO) Plan 006 ($0 monthly premium)

Please contact CHRISTUS Health Plan if you need information in another language or format (Braille).

| **To enroll in one of CHRISTUS Health Plan's Medicare Advantage (HMO) plans, please provide the following:** | | | |
|---|---|---|---|
| LAST NAME FIRST NAME MIDDLE INITIAL | | | Mr. ☐ Mrs. ☐ |
| DATE OF BIRTH (mm/dd/yyyy) | SEX: M ☐ F ☐ | HOME PHONE NUMBER | ALTERNATE PHONE NUMBER |
| PERMANENT RESIDENCE ADDRESS (P.O. Box is NOT allowed) | | | |
| CITY | STATE | COUNTY | ZIP CODE |
| MAILING ADDRESS (Only if different than Permanent Residence Address) | | | |
| EMERGENCY CONTACT INFORMATION<br>NAME: RELATIONSHIP TO YOU:<br>PHONE NUMBER: | | | |
| EMAIL:<br>(Optional) | | | |

| **Please Provide Your Medicare Insurance Information** | |
|---|---|
| Please take out your red, white and blue Medicare card to complete this section.<br>• Fill out this information as it appears on your Medicare card<br>OR<br>• Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. | NAME (As it appears on your Medicare card):<br>MEDICARE NUMBER: _____<br>Is entitled to: Effective Date:<br>HOSPITAL (Part A) _____<br>MEDICAL (Part B) _____<br>You must have Medicare Parts A and B to join a Medicare Advantage Plan. |

## Paying your plan premium

If we determine that you owe a late enrollment penalty (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. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount (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 with- held from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay CHRISTUS Health Plan the Part D-IRMAA.

If the plan you selected has a premium, you can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

People with limited incomes 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 co-insurance. 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 **800.772.1213**. TTY users should call **800.325.0778**. You can also apply for *Extra Help* online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for *Extra Help* with your Medicare prescription drug 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

☐ 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 | RRB 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 withholdings begin. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Applicant Name: _____

Applicant Medicare Number: _____

## Please read and answer these important questions

1. Some individuals may have other drug coverage, including private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State Pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to CHRISTUS Health Plan? ☐ Yes ☐ No

If yes, please list your other coverage and your identification (ID) number(s) for this coverage.

| Name of Coverage | ID # for Coverage | Group # for Coverage |
|---|---|---|
| | | |

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

please provide the following information:

Name of Institution: _____

Address: _____

Phone Number: _____

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

If yes, please provide your Medicaid #: _____

4. Do you or your spouse work? ☐ Yes ☐ No

Provider | PCP Full Name: _____

Phone Number: _____

Provider | PCP ID #: _____

Are you currently seeing or have you recently seen this provider? ☐ Yes ☐ No

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 ☐ Braille ☐ Large print

Please contact CHRISTUS Health Plan at **844.282.3026** if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. to 8 p.m. local time, 7 days a week. Oct. 1 - Mar. 31 and Monday through Friday, Apr. 1 through Sept. 30. TTY users should call **711**.

Applicant Name: _____

Applicant Medicare Number: _____


**Please read this important information.**

If you currently have health coverage from an employer or union, joining CHRISTUS Health Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join CHRISTUS Health Plan.

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 isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

**Please read and sign below.**

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

CHRISTUS Health Plan Generations, Generations Plus and Guardian are Medicare Advantage plans and have a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that 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 that 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 (Example: Oct. 15 - Dec. 7 of every year), or under certain special circumstances.

CHRISTUS Health Plan Medicare Advantage Plan serves a specific service area. If I move out of the area that CHRISTUS Health Plan Medicare Advantage Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of CHRISTUS Health Plan Medicare Advantage Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read either the Member Handbook or Evidence of Coverage document from CHRISTUS Health Plan Medicare Advantage Plan when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

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

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with CHRISTUS Health Plan Medicare Advantage Plan, he/she may be paid based on my enrollment in CHRISTUS Health Plan Medicare Advantage Plan.

Applicant Name: _____

Applicant Medicare Number: _____

Release of Information: By joining this Medicare health plan, I acknowledge that CHRISTUS 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 CHRISTUS Health Plan 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 that if I intentionally provided false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the 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 application. 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 OF APPLICANT* or authorized legal representative (including Power of Attorney, Legal Guardian, etc.)

_____

Signature Date (MM/DD/YYYY) _____

If you are the authorized legal representative, you **MUST** sign above and provide the following information:

Last Name _____ First Name _____ MI _____

Street Address _____

City _____ State _____ Zip Code _____

Telephone Number _____ Relationship to Applicant _____

Applicant Name: _____

Applicant Medicare Number: _____

**Answering these questions is your choice. You can't be denied coverage because you don't fill them out.** (Please click the applicable check box.)

Are you Hispanic, Latino/a, 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
- ☐ **I choose not to answer.**
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban

What's your race? Select all that apply.

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

**AGENT USE ONLY**

Writing Agent Name: Writing Agent Signature:

Print Name: (required) Signature (required)

Plan ID #: _____ Broker NPN #: _____

Effective Date of Coverage: _____

ICEP | IEP:_____ AEP: _____ SEP (type): _____ Not Eligible: _____

Where did this application originate?

☐ Clinic ☐ In-home Appointment ☐ Event ☐ Office ☐ Other

Applicant Name: _____

Applicant Medicare Number: _____

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 received 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 me 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). 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 Special Needs Program (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.

If none of these statements applies to you or you are not sure, please contact CHRISTUS Health Plan at **844.282.3026**, or **711** for TTY users, to see if you are eligible to enroll, Monday through Friday, 8 a.m. to 8 p.m., local time.