Jefferson Health Plans

# Instructions for Completing the Jefferson Health Plans Individual Enrollment Request Form

**Please follow these simple instructions to enroll in any Jefferson Health Plans plan.**
For questions, please call us, 8 a.m. to 8 p.m., seven days a week, from October 1 to March 31.
Call 8 a.m. to 8 p.m., Monday to Friday, from April 1 to September 30.

1) Every applicant must use a separate form. Please do not photocopy this form for reuse.
2) Please read all questions carefully, and complete the Individual Enrollment Request Form and Attestation checklist. Please print clearly to avoid possible delays.
3) Have this information available to help you:
   - Your Medicare card. You will need to complete information exactly as it appears on your red, white and blue card.
   - Your Medicaid number if you receive Medicaid benefits.
   - Your ID card(s) for any other health insurance you may have besides Medicare or Medicaid.
   - The name and provider number of the primary care provider you are choosing. This information can be found in our online Provider & Pharmacy Directory at www.JeffersonHealthPlans.com/medicare.
   - Your permanent residence address. If you use a PO Box to receive mail, please also show your permanent address.
4) Be sure to sign and date this form. A missing signature or date will delay your enrollment.
5) Do not submit duplicate Individual Enrollment Request Forms or apply for the same plan multiple times. This may result in an enrollment delay.
6) To submit your completed Individual Enrollment Request Form and mail it to Jefferson Health Plans at the address below.

***You can enroll in Jefferson Health Plans four ways:***

***Online:*** Visit our website, www.JeffersonHealthPlans.com/medicare, or the Medicare website, www.Medicare.gov.

***Phone:*** Call 1-833-477-4773 (TTY 711).

***Mail:*** Send your completed form to Attn: Sales Dept., Jefferson Health Plans, 1101 Market Street, Suite 3000, Philadelphia, PA 19107.

***Directly:*** Give your completed form to the Jefferson Health Plans representative or your agent for processing.

***Thank you.***

# 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 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) (January 1 - March 31).

☐ I am not new to Medicare but am turning 65.

☐ 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 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 Program of All-inclusive Care for the Elderly (PACE) (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'm 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 request because of the disaster.

☐ I am enrolling during the Annual Enrollment Period, October 15 – December 7.

**If none of these statements applies to you or you're not sure, please contact Jefferson Health Plans at 1-833-477-4773 (TTY users should use 711) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., seven days a week from October 1 to March 31, and Monday to Friday from April 1 to September 30.**

---

## Jefferson Health Plans and Authorized Broker Use Only:

Broker/Agent/Producer Name (printed): _____

Broker/Agent/Producer Signature: _____

Agent Writing Number (AWN): _____

Date application received by Broker/Agent/Producer: _____

Scope of Appointment attached? ☐ Yes ☐ No

OMB No. 0938-1378
Expires: 12/31/2026

Jefferson Health Plans

# Individual 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 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 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.
- 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:

Jefferson Health Plans
Attn: Sales
1101 Market Street, Suite 3000
Philadelphia, PA 19107

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

**How do I get help with this form?**
Call Jefferson Health Plans at 1-833-477-4773. 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 Jefferson Health Plans al 1-833-477-4773 (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.

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

**Select the plan you want to join :**

- ☐ Complete (HMO) – $0/month
- ☐ Giveback (HMO) – $0/month
- ☐ Prime (HMO) – $32.70/month
- ☐ Special (HMO D-SNP) – $32.70/month*
- ☐ Dual Pearl (HMO D-SNP) – $32.70/month*
- ☐ Select (HMO D-SNP) – $32.70/month*
- ☐ Flex (PPO) – $0/month
- ☐ Flex Pro (PPO) – $18/month
- ☐ Flex Plus (PPO) – $32.70/month

*Note: If your level of "Extra Help" changes, you may be responsible for a monthly premium of $32.70.

FIRST name: LAST name: [Optional] 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: [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:**

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Jefferson Health Plans? ☐ Yes ☐ No

Name of other coverage:_____

Member number for this coverage:_____

Group number for this coverage:_____

Do you have full Medicaid coverage? ☐ Yes ☐ No

If "yes" or unsure, please provide your Medicaid number:_____

**IMPORTANT: Read and sign below:**

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Jefferson Health Plans.
- By joining this Medicare Advantage Plan, I acknowledge that Jefferson Health Plans 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 authorizes 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 or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Jefferson Health Plans coverage begins, I must get all of my medical and prescription drug benefits from Jefferson Health Plans. Benefits and services provided by Jefferson Health Plans and contained in my Jefferson Health Plans "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Jefferson Health Plans 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:**

**Prospective Effective Date:**

**If you're the authorized representative, sign above and fill out these fields:**

Name: Address:

Phone number: Relationship to enrollee:

## 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.**

Select 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 ☐ Audio CD ☐ Data CD

Please contact Jefferson Health Plans at 1-866-901-8000 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week, from October 1 to March 31.
Call 8 a.m.—8 p.m., Monday to Friday, from April 1 to September 30. TTY users can call 711.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

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

I want to get the following materials via email. Select one or more.

☐ Member Newsletter

Email 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, Electronic Funds Transfer (EFT) or credit card 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.**

☐ Check/money order (We will bill you)

☐ Electronic funds transfer
(please complete the following form)

☐ Credit card (please complete the following form)

☐ Social Security

☐ Railroad Retirement Board (RRB) benefit

**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.** DON'T pay Jefferson Health Plans the Part D-IRMAA.

## 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: _____ National Producer Number (Agents/Brokers only): _____

**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. Section 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.