OMB No. 0938-1378

Prominence
Medicare Advantage

ENROLLMENT FORM

Prominence Health Plan®
Texas Individual Enrollment Request Form

Medicare Advantage with Prescription Drug Coverage

ENROLLMENT INSTRUCTIONS

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 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:

Prominence Health Plan
1510 Meadow Wood Lane
Reno, NV 89502

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

How do I get help with this form?

Call Prominence Health Plan at 844-677-3747. 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 Prominence Health Plan al 844-677-3747 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

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-NEW. 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 next?" on this page to send your completed form to the plan.

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

Select the plan you want to join

North Texas Counties: Cooke, Deaf Smith, Fannin, Gray, Grayson, Moore, Potter and Randall

- ❑ **Prominence Plus** (HMO) H7680, Plan 001: $0 per month
  - ❑ **Plus Optional Supplemental Dental** $30/month
- ❑ **Prominence Giveback $80** (HMO) H7680, Plan 012: $0/month
  - ❑ **Giveback Optional Supplemental Dental** $31/month

South Texas Counties: Brooks, Cameron, Hidalgo, Jim Hogg, Starr, Webb, Willacy, and Zapata

- ❑ **Prominence Plus** (HMO) H7680, Plan 002: $0 per month
  - ❑ **Plus Optional Supplemental Dental** $30/month
- ❑ **Prominence Beyond** (HMO) H7680, Plan 011: $0 per month
  - ❑ **Beyond Optional Supplemental Dental** $24/month
- ❑ **Prominence Giveback $130** (HMO) H7680, Plan 014: $0/month
  - ❑ **Giveback Optional Supplemental Dental** $31/month
- ❑ **Prominence Extra Help** (HMO) H7680, Plan 009: $0 per month
- ❑ **Prominence Dual** (HMO-DSNP) H7680, Plan 007: $0 per month

FIRST Name: (use boxes below) LAST Name: (use boxes below) MI: (optional)

Birth Date: MM DD YYYY Sex: ❑ M ❑ F

Phone Number:
❑ Check if this is a cell phone (optional)

Alternate Phone Number: (optional)
❑ Check if this is a cell phone (optional)

Permanent Residence Street Address:
(Don't enter a PO Box)

Street Number Street Name Lot/Apartment

City: State: Zip Code:

County:

Mailing Address if different from your Permanent Residence Address (PO Box allowed):

Street Number Street Name Lot/Apartment

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 Prominence Health Plan?

❑ YES ❑ NO

Name of other coverage:

Member number for this coverage: Group # for this coverage:

Are you enrolled in your State Medicaid program? ❑ YES ❑ NO

If yes, please provide your Medicaid number:

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IMPORTANT: Please Read and Sign Below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Prominence Health Plan.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Prominence Health Plan 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 Prominence Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Prominence Health Plan. Benefits and services provided by Prominence Health Plan and contained in my Prominence Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Prominence Health Plan 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.

Signature: ______________________

Today's Date: MM / DD / YYYY

If you are the authorized representative, sign above and fill out these fields:

Name: ______________________ **Phone Number:** ______________________

Address: ______________________

Relationship to Enrollee: ______________________

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.

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ❑ No, not of Hispanic, Latino/a, or Spanish origin
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, another Hispanic, Latino/a, or Spanish origin
- ❑ **I choose not to answer.**

What's your race? Select all that apply.

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

Select one if you want us to send you information in a language other than English.

❑ Spanish Written ❑ Spanish Spoken ❑ Vietnamese Written ❑ Vietnamese Spoken

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

❑ Braille ❑ Large print ❑ Audio CD

Please contact Prominence Health Plan at 855-969-5882 if you need information in an accessible format other than what's listed above. Our office hours are 8 am to 8 pm, seven days a week from October 1 through March 31 and Monday through Friday from April 1 through September 30. TTY users can call 711.

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

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: Phone Number: Address: (Number and Street)

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

FIRST Name: (use boxes below) MI: LAST Name:

Are you an existing member of this PCP? ❑ YES ❑ NO

ELECTRONIC COMMUNICATION

I want to get the following materials via email.

❑ Required plan documents: for example the Annual Notice of Change.

E-mail Address:

We may also send communications related to care management or health and wellness information through text messages.

❑ Check here if you prefer not to receive any text messages.

❑ Check here if you agree to receive marketing messages such as benefit information, new services or invitations to member events in your area.

PAYING YOUR PLAN PREMIUMS

You can pay any monthly plan premium (your plan has no monthly premium) including any late enrollment penalty that you currently have or may owe by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your late enrollment penalty by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.

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 (your plan has no monthly 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 Prominence Health Plan 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) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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:

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

First | Last | Agent ID#:

Signature: ______________________________

Plan ID#: ☐☐☐

Effective Date of Coverage: (M M /D D/ Y Y Y Y)

Election Type: ❑ ICEP/IEP ❑ AEP ❑ MA OEP ❑ SEP (TYPE) ❑ Not Eligible

Current Insurance: ______________________

TR K-1 ❑ Referral by Provider ❑ Referral by Member ❑ Company Website ❑ Media (TV, News Ad, Mag) ❑ Direct Mail ❑ Local Community Event ❑ Word of Mouth

Online/Telephonic Application Confirmation #

Date Received:

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Information to include with Enrollment Mechanism

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 (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ I recently was released from incarceration. I was released on (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ I recently obtained lawful presence status in the United States. I got this status on (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ 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 (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ 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 (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ I recently left a PACE program on (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ I am leaving employer or union coverage on (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ 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 (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ 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 (MM-DD - YYYY) ☐☐ ☐☐ ☐☐☐☐
- ❑ 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 Prominence Health Plan at 1-855-969-5882 (TTY users should call 711) to see if you are eligible to enroll. We are open 8 am to 8 pm, seven days a week from October 1 - March 31 and Monday through Friday from April 1 – September 30.

OFFICE USE ONLY:

Enrollee's LAST Name: (use boxes below) FIRST Name: MI:

Medicare #

Effective Date: M M D D Y Y Y Y