OMB No. 0938-1378

Prominence
Medicare Advantage

ENROLLMENT FORM

Prominence Health Plan®
North 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 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.

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 0938-1378. 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/month — ❑ **Plus Optional Supplemental Dental:** $46/month
- ❑ **Prominence Beyond** (HMO) H7680, Plan 019: $0/month — ❑ **Beyond Optional Supplemental Dental:** $42/month
- ❑ **Prominence Giveback** (HMO) H7680, Plan 012: $0/month — ❑ **Giveback Optional Supplemental Dental:** $47/month
- ❑ **Prominence Diabetes & Heart Plan** (HMO-CSNP) H7680-015: $0/month — ❑ **Diabetes & Heart Optional Supplemental Dental:** $46/ month
- ❑ **Prominence Extra Help** (HMO) H7680-018: $0/month — ❑ **Extra Help Optional Supplemental Dental:** $46/month
- ❑ **Prominence Dual** (HMO-DSNP) H7680-017: $0/month

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

Birth Date: M M / D D / Y Y Y Y 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) Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address:

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:

Prominence Medicare Advantage

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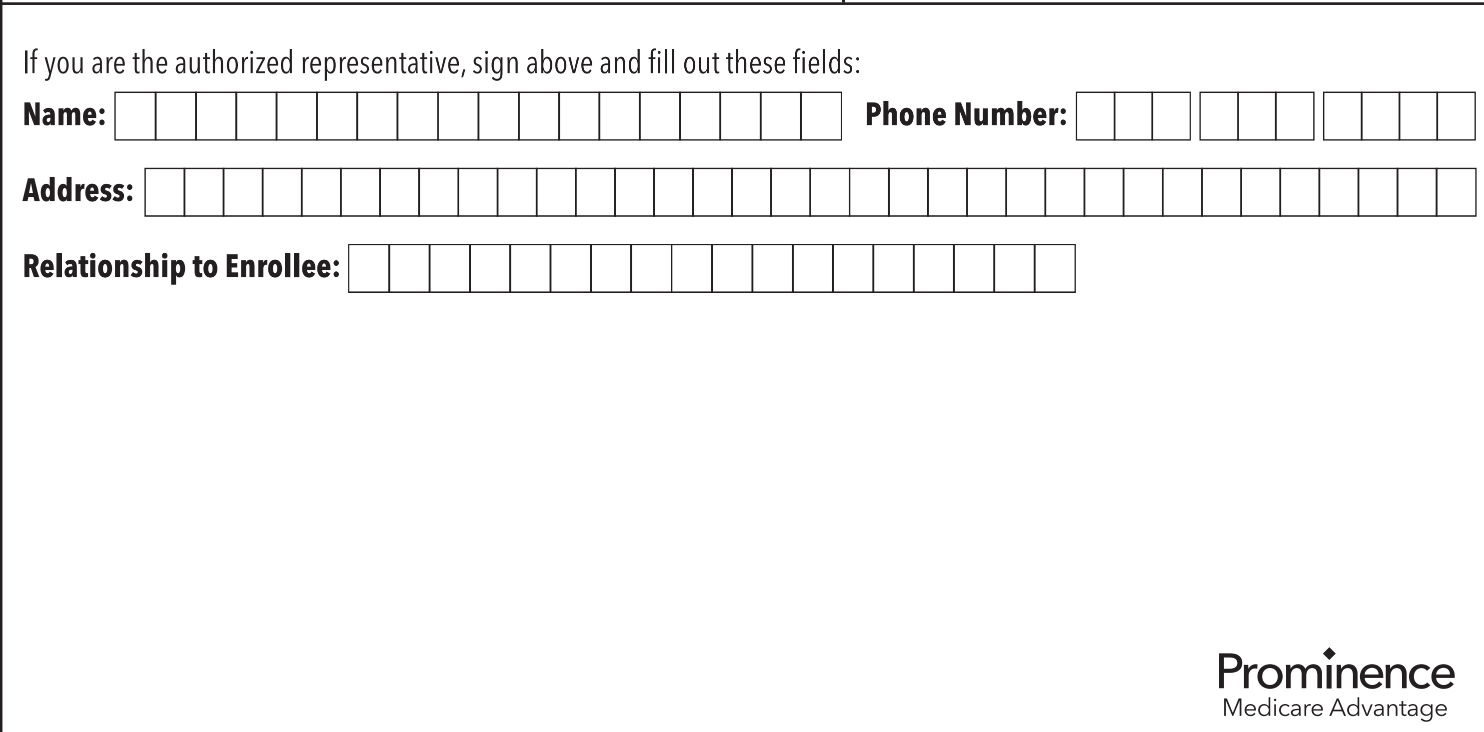
IMPORTANT: Please Read and Sign Below

- 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.
- 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 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.
- 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: M M / D D / Y Y Y Y

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 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
❑ Black or African American
❑ White
❑ **I choose not to answer.**

Asian:
❑ Asian Indian
❑ Chinese
❑ Filipino
❑ Japanese
❑ Korean
❑ Vietnamese
❑ Other Asian

Native Hawaiian and Pacific Islander:
❑ Guamanian or Chamorro
❑ Native Hawaiian
❑ Samoan
❑ Other Pacific Islander

What is your gender? Select one.

❑ Woman ❑ Man ❑ Non-binary ❑ I use a different term: ____________________
❑ **I choose not to answer.**

Which of the following best represents how you think of yourself? Select one.

❑ Lesbian or gay ❑ Straight, that is, not gay or lesbian ❑ Bisexual
❑ I use a different term: ____________________ ❑ I don't know ❑ **I choose not to answer.**

❑ **Select if you want us to send you information in Spanish.**

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

❑ Braille ❑ Large print ❑ Audio CD ❑ Data 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

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.

Mobile phone number:

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

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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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.

Reason for Annual Enrollment Period Eligibility

❑ I am enrolling between October 15 and December 7 during the Annual Enrollment Period.

Reasons for Initial Enrollment Period Eligibility

❑ I am new to Medicare.

❑ I already have Hospital (Part A) and recently signed up for Medical (Part B). I want to join a Medicare Advantage Plan.

❑ I am new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started. I was notified on__/__/____ (Date).

❑ I previously had Medicare, but I'm now turning 65. (IEP2)

Reasons for Open Enrollment Eligibility

Between January 1 and March 31

❑ I am enrolled in a Medicare Advantage plan and want to make a change.

Between April 1 and December 31

❑ I am enrolled in a Medicare Advantage plan and have had Medicare for less than 3 months. I want to make a change.

Reasons for Special Enrollment Eligibility

❑ I lost my Special Needs Plan (SNP) because I no longer qualify to be in that plan. I was disenrolled from the SNP on __/__/____ (Date).

❑ I want to join a Special Needs Plan that tailors its benefits to my chronic condition.

❑ 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.

❑ I recently had a change in my Medicaid (newly received Medicaid, had a change in level of Medicaid assistance or lost Medicaid on __/__/____ (Date).

❑ I recently had a change in my Extra Help paying for my drug costs (newly received Extra Help, had a change in the level of Extra Help or lost Extra Help) on __/__/____ (Date).

❑ I 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 __/__/____ (Date).

❑ I recently moved back to the United States after permanently living out of the country. I returned to the United States on __/__/____ (Date).

❑ I was recently released from jail or prison. I was released on __/__/____ (Date).

❑ I recently received lawful presence status in the United States. I received this status on __/__/____ (Date).

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- ❑ I live in a long-term care facility, like a nursing home or rehabilitation hospital. I moved/will move into the facility on __/__/____ (Date).
- ❑ I recently moved out of a long-term care facility, like a nursing home or rehabilitation hospital. I moved out of the facility on __/__/____ (Date).
- ❑ I am leaving employer or union coverage (including COBRA coverage) on__/__/____ (Date).
- ❑ I recently involuntarily lost my creditable prescription drug coverage (coverage equivalent to Medicare's). I lost my drug coverage on __/__/____ (Date).
- ❑ I lost my coverage because my plan no longer covers the area where I live or it ended its contract with Medicare.
- ❑ I lost my coverage because Medicare ended its contract with my plan. I got a letter from Medicare saying I could join another plan.
- ❑ I dropped my coverage in a PACE (Programs of All-Inclusive Care for the Elderly) 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 __/__/____ (Date).
- ❑ I am in a State Pharmaceutical Assistance Program or I am losing help from a State Pharmaceutical Assistance Program.
- ❑ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by federal, my state or my local government). One of the other statements here applied to me, but I was unable to make my enrollment because of the disaster.
- ❑ I'm in a plan that's had a star rating of less than 3 stars for the last 3 years. I want to join a plan with a star rating of 3 stars or higher.
- ❑ I'm in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan.
- ❑ I requested Medicare information in an accessible format. I got less time to make my decision, or I didn't get it in time to make a choice before my enrollment period ended.
- ❑ I pay a premium for Part A and I signed up for Part B during the General Enrollment Period (January 1 - March 31 each year). I want to join a Medicare drug plan (Part D) or Medicare Advantage Plan with drug coverage.
- ❑ I signed up for a Part A (Hospital Insurance) or Part B (Medical Insurance) during a Special Enrollment Period I qualified for because of an exceptional circumstance. I want to join a Medicare Advantage Plan.
- ❑ Other ____

If you have questions you can call us at 855-969-5882 (TTY: 711). We are open 8 a.m. to 8 p.m., 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: MM DD YYYY

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Prominence
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Pre-qualification Form – Texas Regions

PROMINENCE DIABETES & HEART PLAN (HMO-CSNP)

The Prominence Diabetes & Heart Plan has been created for people with diabetes, cardiovascular disease or congestive heart failure. You may be eligible for this plan if you answer yes to the questions below. Medicare requires that your primary care provider (PCP) or cardiologist verifies you have heart disease or diabetes. We will work with your provider to confirm that you have one or more of the qualifying conditions below. If a provider cannot confirm a diagnosis, you will not be eligible to enroll in this plan.

NOTE: This plan is currently only available to Texas members.

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

Birth Date: M M / D D / Y Y Y Y   Medicare ID (MBI/NICN): ____ - ___ - ____

Provider Currently Treating the Condition(s)

Physician Name: ______________________ Physician Phone #: ______________

Other Treating Specialists

Physician Name: ______________________ Physician Phone #: ______________

Physician Name: ______________________ Physician Phone #: ______________

Physician Name: ______________________ Physician Phone #: ______________

❑ I authorize Prominence Health to request medical records from my physician(s)

Pre-Qualification Questions

(This is a pre-assessment, verification by your provider will occur after you are enrolled in the plan.)

Have you ever been told by a doctor or clinic that you have one or more of the following conditions. If so, please check all that apply:

❑ Diabetes,

❑ Cardiac arrhythmias,

❑ Coronary artery disease,

❑ Peripheral vascular disease,

❑ Chronic venous thromboembolic disorder, and

❑ Congestive heart failure

Completing this pre-assessment does not guarantee continued enrollment in the plan. Verification from a provider or specialist is required. You will also be required to complete a Prominence Health Assessment within 90 days.

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Medicare Advantage

CHRONIC CONDITION VERIFICATION RELEASE OF INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal law concerning the privacy of such information.

I (insert applicant name) ____________________________________, hereby authorize the disclosure of my health information described above in order to enroll in this HMO-CSNP plan. I understand that my healthcare provider must certify that I have been diagnosed with a qualifying condition to be enrolled in the plan.

Applicant Signature: ____ Date: ____________________________________

If you are the authorized representative of the applicant, provide the following information:

Relationship to Applicant: ____________________________________ Telephone Number: _________________________