MMM of Florida Healthcare Plan

Individual Enrollment Request Form - 2020

Medicare and Much More

Be sure to complete the entire enrollment form. Then, mail the completed form to MMM of Florida, Inc. Attn: Sales Dept 5775 Blue Lagoon Dr. Ste 190 Miami, FL. 33126 or fax the completed form to 786-584-4596. You can also enroll online at www.medicare.gov. Note: Your agent/broker may provide different instructions.

Please contact MMM of Florida, Inc. if you need information in another language or format (Large Print). This document is available in our web page www.mmm-fl.com for immediate access.

Please check which plan you want to enroll in.	
☐ MMM Elite Dade (HMO) $0.00 per month	☐ MMM Extra (HMO) $0.00 per month
☐ MMM Plus (HMO) $0.00 per month	☐ MMM Platinum (HMO-SNP) $28.50 per month
☐ MMM Elite (HMO) $0.00 per month	☐ MMM More (HMO-SNP) $28.50 per month

Last name	First name	MI

Birthdate (MM/DD/YYYY)	Gender ☐ M ☐ F	Home phone number	Alternate phone number

Email Address:	Are you a veteran? ☐ Yes ☐ No

Permanent residence street address (P.O. Box is not allowed.)			
City	**State**	**ZIP code**	**County**

Mailing address (only if different from your permanent residence address)		
City	**State**	**ZIP code**

Please provide your Medicare insurance information	
Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card. -OR- • 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): _____ Medicare Number: _____ Is Entitled To: Effective Date: HOSPITAL (Part A) _____ MEDICAL (Part B) _____ You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Applicant Complete Name_____ and Medicare Number_____

Paying your plan premium

You can pay your monthly plan premium, (including any late enrollment penalty that you currently have or may owe) by mail each month. 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 (D-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 withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board (RRB). DO NOT pay MMM of Florida, Inc. the Part D-IRMAA.

For beneficiaries who are enrolling in a Medicare Advantage Prescription Drug with zero premium:
If we determine that you owe a late enrollment penalty (or if you currently have late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail, each month. You can also choose to pay by benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-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 every month. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay MMM of Florida, Inc. the Part D-IRMAA.

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 coinsurance. 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 1-800-772-1213. TTY users should call 1-800-325-0778. You also can apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage 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 choose one of the options below:

☐ **Monthly Bill:** Send me a bill each month

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/Railroad Retirement Board (RRB) deduction may take two or more months to begin after Social Security or Railroad Retirement Board (RRB) approves the deduction. In most cases, if Social Security or Railroad Retirement Board (RRB) accepts your request for automatic deduction, the first deduction from your Social Security or Railroad Retirement Board (RRB) benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or Railroad Retirement Board (RRB) does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Applicant Complete Name_____ and Medicare Number_____

Please read and answer these important questions:

1. **Do you have end-stage renal disease (ESRD)?** ☐ Yes ☐ No

If you were diagnosed with ESRD, and have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need regular dialysis, otherwise we may need to contact you to obtain additional information.

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

Will your current prescription drug coverage be ending? ☐ Yes ☐ No ☐ N/A

Will you continue to have other prescription drug coverage? ☐ Yes ☐ No ☐ N/A

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

Dates Covered:Start __ __ _____ **End** __ __ _____ Name of other coverage_____

ID # for this coverage_____ Group # for this coverage_____

3. **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_____

Address_____

City_____ State_____ ZIP code_____ Phone number_____

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

If "yes," please provide your Medicaid number_____

5. **Do you or your spouse work?** ☐ Yes ☐ No

6. **Please choose the name of a primary care physician (PCP).** If you do not choose a PCP, one will be selected for you **(as shown in the Provider and Pharmacy Directory).**

PLID #: _____

PCP name_____ _____
First Name Last Name

Primary Medical Group (PMG) name_____

PCP address _____

City_____ State_____ ZIP code _____

New physician for you? ☐ 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:

☐ English ☐ Spanish

Assistance for the visually impaired:

☐ Regular Print ☐ Large Print

Please contact MMM of Florida, Inc., at **1-844-212-9858** if you need information in an accessible format or language other than what is listed above. From October 1 to March 31, we are open seven days a week from 8:00 a.m. - 8:00 p.m. ET. Beginning April 1 to September 30, we are open Monday through Friday, 8:00 a.m. - 8:00 p.m. ET. TTY users should call 711.

Applicant Complete Name_____ and Medicare Number_____

STOP

Please read this important information.

If you currently have health coverage from an employer or union, joining MMM of Florida, Inc. could affect your employer or union health benefits. You could lose your employer or union health coverage if you join MMM of Florida, Inc. 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.

Typically, you may enroll in a Medicare Advantage (MA) plan during the Annual Enrollment Period (AEP) between October 15 and December 7 of each year or during the Open Enrollment Period (OEP) between January 1 to March 31. Beneficiaries enrolled in a MA-PD plan may use the OEP to switch to another MA-PD plan; a MA-only plan; or Original Medicare with/without a PDP. Additionally, there are exceptions-i.e., Initial Enrollment Period (IEP/ICEP) and Special Enrollment Periods (SEPs) - that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements carefully and check all of the boxes where there is a statement that 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.

NOTE: You must select at least one of the options below.

- ☐ I am enrolling during the Annual Open Enrollment Period from October 15 to December 7. (AEP)
- ☐ I am new to Medicare. (IEP/ICEP)
- ☐ I am turning 65 and not new to Medicare. (IEP2)
- ☐ 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)_____. (SEP)
- ☐ 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. (SEP)
- ☐ 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)_____. (SEP)
- ☐ 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)_____ . (SEP)
- ☐ 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. (SEP)
- ☐ I recently had a change in my Extra Help paying for my Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date)_____ . (SEP)
- ☐ 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)_____. (SEP)
- ☐ I recently left a Program of All-inclusive Care for the Elderly (PACE®) program on (insert date)_____. (SEP)
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____ . (SEP)
- ☐ I am leaving employer or union coverage on (insert date)_____ . (SEP)
- ☐ I belong to a pharmacy assistance program provided by my state. (SEP)
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date)_____. (SEP)
- ☐ My plan is ending its contract with Medicare or Medicare is ending its contract with my plan. (SEP)

Applicant Complete Name_____ and Medicare Number_____

☐ 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)_____. (SEP)

☐ I was recently released from incarceration. I was released on (insert date)_____. (SEP)

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date)_____. (SEP)

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period. (MA OEP)

☐ Other* _____

*Please contact MMM of Florida, Inc. at 1-844-212-9858. From October 1 to March 31, we are open saven days a week from 8:00 a.m. - 8:00 p.m. ET. Beginning April 1 to September 30, we are open Monday through Friday, 8:00 a.m. - 8:00 p.m. ET (TTY users should call 711) to see if you are elegible to enroll.

Please read and sign in the "Applicant signature" box below

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

MMM of Florida, Inc. is a Medicare Advantage plan and has 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 or prescription drug plan. It is my responsibility to inform MMM of Florida, Inc. 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 (for example, October 15-December 7 of every year), or under certain special circumstances.

MMM of Florida, Inc. serves a specific service area. If I move out of the area that MMM of Florida, Inc. 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 MMM of Florida, Inc., I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from MMM of Florida, Inc. 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 usually aren't covered under Medicare while out of the country except for limited coverage near the U.S. border. I understand that beginning on the date MMM of Florida, Inc. coverage begins, I must get all of my health care from MMM of Florida, Inc., except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by MMM of Florida, Inc. and other services contained in my MMM of Florida, Inc. Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MMM OF FLORIDA, INC. 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 MMM of Florida, Inc., he/she may be paid based on my enrollment in MMM of Florida, Inc.

Release of Information: By joining this Medicare health plan, I acknowledge that MMM of Florida, Inc. will release my information to Medicare and other plans as is necessary for treatment, payment and helath care operations. I also acknowledge that MMM of Florida, Inc. will release my information: including my prescription drug event data (if apply), 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 provide 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.

Applicant Complete Name_____ and Medicare Number_____

Signature Required to process your application.

Applicant or Legal representative signature: X	Today's date:
Desired plan effective date*:	

*Subject to Medicare election period guidelines

Authorized Representative Information Only		
All fields within this section must be completed if the application has been signed by an Authorized Representative and not the Applicant.		
Name	Last Name	
Address		
City	State	ZIP code
Phone Number	Relationship to Enrollee	

Select the documents you want to receive electronically to the email address provided on this form. If you opt-out to receive information by email, please check the documents received in paper.

Documents	**Requested by Email**	**Received from Sales Representative / Broker**
Pre-Enrollment Checklist	☐	☐
Provisional Proof of Enrollment	☐	☐
Star Rating Letter	☐	☐
Summary of Benefits (SB)	☐	☐
LIS Summary Premium	☐	☐
Annual Notice of Changes (if applicable)	☐	☐
Evidence of Coverage (EOC) (includes the Privacy Notice)	☐	☐
Notification of electronic EOC & Providers and Pharmacy Directory	☐	☐
Providers and Pharmacy Directory	☐	☐
Drug Formulary	☐	☐
OTC Catalog (if applicable)	☐	☐
Privacy Notice	☐	☐
Non-Discrimination Notice	☐	☐
Multi-Language	☐	☐

Applicant Complete Name_____ and Medicare Number_____

Applicant: Please do not complete the following sections.
Agent/Broker: Please fill in ALL fields including 'Writing Agent' and 'Agency' with your assigned Encrypted ID, Code, or Tax ID based on your appointed brand, state AND product.

Coverage effective date_____ PLAN ID #:_____

☐ IEP/ICEP ☐ AEP ☐ OEP ☐ SEP (type):_____ ☐ Not eligible

I helped the applicant fill out this application. ☐ Yes ☐ No

Was this an individual face-to-face appointment? ☐ No ☐ Yes (if yes, how was a scope of appointment (SOA) collected)? ☐ Electronic ☐ Paper

☐ Recorded call (voice recording ID) _____

Print name _____

Sales Location: ☐ Seminar ☐ In-Home ☐ Mail ☐ In-Office ☐ Fax ☐ Institution/Home

☐ Walk-in ☐ PCP Location ☐ UCID Tel: _ _ _-_ _ _-_ _ _ _ ☐ Institution Tel: _ _ _-_ _ _-_ _ _ _ ☐ Other

Where did you find information about the plan: ☐ Newspaper ☐ PCP Office ☐ Billboard ☐ Mail

☐ Magazine ☐ TV ☐ Agent/Employee ☐ Brochure ☐ Internet ☐ Radio ☐ Friend/Family Referral

☐ Retail Location ☐ Marketing Event ☐ Other

Writing Agent TIN (10 digits)/Agent Code ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Agency TIN (10 digits) or Agency Code___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Agency Name_____

Street address _____

City_____ State _____ ZIP code_____

Phone_____ Fax_____

Email _____

Signature _____ Application received date _____

MMM of Florida, Inc., is a Medicare-contracted coordinated care plan that has a Medicaid contract with the State of Florida Agency for Health Care Administration to provide benefits or arrange for benefits to be provided to enrollees. Enrollment in MMM of Florida, Inc. depends on contract renewal.
ATENCIÓN: Si habla español, los servicios de asistencia lingüistica están disponibles sin costo alguno para usted. LLame al 1-844-212-9858 (TTY: 711)

If this authorization is signed by the assigned legal representative, please provide any representative documentation as required by state law (e.g. Power of Attorney, Legal Guardianship).

MMM of Florida, Inc. is an HMO plan with a Medicare contract. Enrollment in MMM of Florida, Inc. depends on contract renewal. MMM of Florida, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MMM of Florida Inc. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-212-9858 (TTY: 711). MMM of Florida Inc. konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks. ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-212-9858 (TTY: 711).
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MMM
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Applicant Complete Name_____ and Medicare Number_____