OMB No. 0938-1378
Expires:7/31/2023

Enrollment Form 2022

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

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 January1)
- 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:

MMM Medicare and Much More
P.O. Box 260370
Miami FL 33126

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

How do I get help with this form?

Call MMM Medicare and Much More at 1-844-212-9859. 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 MMM Medicare and Much More al 1-844-212-9859 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

ENROLLMENT APPLICATION

Please contact **MMM Medicare and Much More**, (HMO) and (HMO-SNP), if you need information in another language or format (for example braille).

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

To enroll in MMM Medicare and Much More, please provide the following information: (please print)

Please check which plan you want to enroll in:

- ❑ 003 MMM Extra (HMO), $0 per month.
- ❑ 005 MMM Elite (HMO), $0 per month.
- ❑ 004 MMM Platinum (HMO-SNP), $34.30 per month.

*If you receive Extra Help for drugs, the Extra Help program will pay all or part of your monthly plan premium.

Tell us about yourself (please print)

Last Name:	First Name:	Middle Initial (optional):
❑ Mr. ❑ Mrs. ❑ Ms. ❑ Male ❑ Female	Email Address (optional):	

Home Telephone Number:	Birth Date (MM/DD/YY):	Alternate Phone (optional):

Permanent Residence Street Address (PO Box is not allowed):	City:	State:	Zip Code:
Mailing Address (If different from above) (PO Box allowed):	City:	State:	Zip Code:

Emergency contact (optional):	Telephone Number (optional):	Relationship with you (optional):

Medicare Number: _____ HOSPITAL (Part A): _____

MEDICAL (Part B): _____

H3293_2022 1070 0001 1_C CMS Approved 09/02/2021

MMM

Are you enrolled in your State Medicaid program? - ❑ **Yes** ❑ **No**

If yes, please provide your Medicaid number: _____

Answer these important questions:

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State pharmaceuticals assistance programs. Will you have other prescription drug coverage in addition to MMM Medicare and Much More? - ❑ **Yes** ❑ **No**

If "YES", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	ID# for this coverage:	Group # for this coverage:

IMPORTANT: Read and sign below:

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

If you are the authorized representative, you must sign above and provide the following information:

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.

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format: ❑ **English** ❑ **Spanish** Assistance for the visually impaired: ❑ **Regular Print** ❑ **Large Print**

Preferred speaking language? ❑ **Spanish** ❑ **English** ❑ **Creole**

Please contact MMM Medicare and Much More, at 1-844-212-9858 if you need information in an accessible format or language other than what is listed above (for example Braille or Audio CD). 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.

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

Are you resident in a long-term care facility, such as a nursing home? - ❑ **Yes** ❑ **No**

If yes, Name of Institution: _____ Phone Number: _____

Address of institution (number and street): _____

Please choose the name of a Primary Care Physician (PCP) and Physician Group:

PCP First Name:	M.I.:	Last Name:	
Primary Medical Group (spell out completely):		PLID ID#:	
PCP Address:	City:	State:	Zip Code:

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 Rep./Broker
Pre-Enrollment Checklist		❑
Provisional Proof of Enrollment		❑
Star Rating Letter	❑	❑
Summary of Benefits (SB)	❑	❑
LIS Summay Premium	❑	❑
Annual Notice of Coverage	❑	❑
Evidende of Coverage (EOC) (includes the Privacy Notice)	❑	❑
Notification of electronic EOC & Providers and Pharmacy Directory	❑	❑
Providers and Pharmacy Directory	❑	❑
Drug Formulary	❑	❑
OTC Catalog	❑	❑
Privacy Notice	❑	❑
Non-Discrimination Notice	❑	❑
Multi-Language	❑	❑

❑ I understand I can change my mind at any time and go back to receiving hard copy mailings by contacting MMM Medicare and Much More, at 1-844-212-9858. 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.

My email address is: **(PLEASE PRINT NEATLY. ONE LETTER, ONE NUMBER OR CHARACTER PER BOX)**

❑ No, I would like to receive hard copy materials.

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 elegible 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 was recently 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 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) _____ .
- ❑ 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 (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 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 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.

Paying Your Plan Premium

You can pay your monthly plan premium (plan 004) (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 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. 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 MMM Medicare and Much More, the Part D-IRMAA.

If you don't select a payment option, you will get a bill each month;

Please select a premium payment option:

❑ Get a monthly bill

❑ Automatic deductions from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (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 withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Select Deduction: ☐ Social Security ☐ Railroad Retirement Board (RRB)

AGENT/BROKER USE ONLY

Name of Agent/Broker (is assisted in enrollment): _____

General Agency (GA) Name (if applicable): _____

Agent/Broker Signature (if assisted in enrollment): _____

CA Insurance License No.: _____ Application Receive Date: _____

Effective Date of Coverage: _____

❑ ICEP/IEP ❑ AEP ❑ SEP (TYPE) ❑ MA OEP ❑ NOT ELEGIBLE

OFFICIAL USE ONLY

Confirmation ID: _____ Enrollee ID: _____

Department Received Date: _____

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. Sections 1851 and 1860D-1 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.