CENTRAL HEALTH MEDICARE PLAN

OMB No. 0938-1378
Expires: 6/30/2026

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 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:
Central Health Medicare Plan
PO Box 22800,
Long Beach, CA 90801
Attention: Enrollment Department

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

How do I get help with this form?
Call Central Health Medicare Plan at 1-866-314-2427. 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 Central Health Medicare Plan al 1-866-314-2427, 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.

CENTRAL HEALTH MEDICARE PLAN

Enrollment Application

PO Box 22800,
Long Beach, CA 90801

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

Select the plan you want to join:

MAPD

☐ **Central Health Classic Care Plan I (HMO) 027** (LA/OC/RS/SB/SD) $0 per month
☐ **Central Health Classic Care Plan II (HMO) 028** (AL/CC/FR/IM/KE/KI/MA/PL/SA/SF/SJ/SM/SC/SO/ST/TU/YO) $0 per month
☐ **Central Health Jade Plan (HMO) 022** (LA) $0 per month
☐ **Central Health Medicare Plan (HMO) 001** (LA/OC/RS/SB) $0 per month
☐ **Central Health Premier Plan I (HMO) 023** (AL/CC/FR/SF/SJ/SC/SO) $0 per month
☐ **Central Health San Mateo Medicare Plan (HMO) 018** (SM) $0 per month
☐ **Central Health Ventura Medicare Plan (HMO) 008** (VC) $0 per month

MA

☐ **Central Health Valor Care Plan (HMO) 030** (FR/IM/KE/KI/LA/MA/OC/RS/SA/SB/SD/SF/SJ/SM/SC/TU) $0 per month

Part B Savings

☐ **Central Health Part B Savings Plan (HMO) 029** (LA/OC/RS/SB/SD) $0 per month
☐ **Central Health Savings Plan (HMO) 019** (LA/OC/RS/SB) $0 per month

C-SNP

☐ **Central Health Embrace Care Plan (HMO C-SNP) 025-1** (LA/OC/RS/SB/SD) $0 per month
☐ **Central Health Embrace Care Plan (HMO C-SNP) 025-2** (AL/CC/FR/IM/KE/KI/MA/PL/SA/SF/SJ/SM/SC/SO/ST/TU/YO) $0 per month
☐ **Central Health Embrace Choice Plan (HMO C-SNP) 026-1** (LA/OC/RS/SB/SD) $13.40 per month
☐ **Central Health Embrace Choice Plan (HMO C-SNP) 026-2** (AL/CC/FR/IM/KE/KI/MA/PL/SA/SF/SJ/SM/SC/SO/ST/TU/YO) $13.40 per month
☐ **Central Health Focus Plan (HMO C-SNP) 006** (AL/CC/FR/LA/OC/SB/SJ/SC) $0 per month

D-SNP

☐ **Central Health Medi-Medi Plan I (HMO D-SNP) 002** (LA/RS/SA/SB/SD) $13.60 per month

Last Name:	First Name:	Middle Initial (optional):

Birth Date: (MM/DD/YYYY)	Sex:	Home Phone Number:	Cell Phone Number:
_ _ /_ _ /_ _ _ _	☐ Male ☐ Female	(_ _ _) _ _ _ - _ _ _ _	(_ _ _) _ _ _ - _ _ _ _

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

City:	County (optional):	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: _ _ _ _ - _ _ _ - _ _ _ _

Applicant Name: _____

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

Answer these important questions:

Will you have other prescription drug coverage (like VA/TRICARE) in addition to Central Health Medicare Plan? ☐ Yes ☐ No

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

Are you enrolled in your state medicaid (medi-cal) program?

☐ Yes ☐ No

Medicaid (Medi-Cal) Number: _____

Medicaid (Medi-Cal) DOB: _____

To qualify for Central Health Embrace Care Plan (HMO C-SNP) 025-1, Central Health Embrace Care Plan (HMO C-SNP) 025-2 , Central Health Embrace Choice Plan (HMO C-SNP) 026-1, Central Health Embrace Choice Plan (HMO C-SNP) 026-2, Central Health Focus Plan (HMO C-SNP) 006 conditions.

Have you been diagnosed with one of the following? Please check all that apply.

☐ Diabetes ☐ Congestive Heart Failure ☐ Cardiovascular Disorders

Please also complete the Pre-Enrollment Qualification Assessment Tool (PQAT) included with this form before submitting your application. The PQAT must be submitted with your enrollment form.

IMPORTANT: Read and Sign below:

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

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

Name:	Address:
Phone number:	Relationship to enrollee:

Applicant Name: _____

Section 2 – All fields 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, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Black or African American

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer.**

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

- ☐ Arabic
- ☐ Armenian
- ☐ Cambodian
- ☐ Chinese
- ☐ Farsi
- ☐ Hmong
- ☐ Korean
- ☐ Punjabi
- ☐ Russian
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese

Applicant Name: _____

Section 2 – All fields are optional

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

☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Please contact Central Health Medicare Plan at 1-866-314-2427 (TTY: 711), if you need information in an accessible format other than what is listed above. Our office hours are 8:00 AM – 8:00 PM PT, 7 days a week (October 1 – March 31) and Monday – Friday (April 1 – September 30).

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

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

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

☐ Member Communication/Documents

Email address: _____

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 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. DON'T pay Central Health Medicare Plan the Part D-IRMAA.

Please select a premium payment option

If you don't select a payment option, you will get a bill each month.
Please select a premium payment option:

☐ Get a bill
☐ Automatic deduction from your monthly Social Security benefit check
☐ Automatic deduction from your monthly Railroad Retirement Board (RRB) benefit check
☐ ACH Payment

Account holder name:_____ Account type: ☐ Checking ☐ Savings

Bank account number:_____ Bank routing number:_____

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): _____

Agents can fax completed enrollment forms and associated documents to **1-844-541-6848**
The receipt date of enrollment will be used to determine the election period in which request was made, which in turn will determine the effective date of coverage.

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 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.