

Individual Enrollment Request Form to Enroll in SFHP Care Plus (HMO D-SNP), a Medicare Medi-Cal Plan

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 Dual-Eligible Special Needs Plan, you must also have:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)
- Medi-Cal (The State of California's Medicaid Insurance for low-income individuals)

When do I use this form?

This plan is a Dual Eligible Special Needs Plan (D-SNP) that operates under the Integrated Care Special Enrollment Period. Eligible members may enroll at any time during the year, with coverage effective the first day of the next calendar month following enrollment.

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:

Because this is a Dual Eligible Special Needs Plan (D-SNP), eligible members may enroll any time of year through a month-to-month Special Enrollment Period (SEP).

What happens next?

Send your completed and signed form to:

SFHP Care Plus (HMO D-SNP)
San Francisco Health Plan
P.O. Box 194247
San Francisco, CA 94119

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

How do I get help with this form?

Call SFHP Care Plus at **1(415) 988-8500** or **1(844) 254-8500** (toll-free). 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 SFHP Care Plus al **1(415) 727-2273** o **1(888) 765-7327** (llamada gratuita), 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.

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.

SFHP Care Plus (HMO D-SNP) Enrollment Form

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

Select the plan you want to join: ☐ SFHP Care Plus (HMO D-SNP) — \$0 per month

FIRST name: _____ LAST name: _____ Middle Initial: _____

Birth date: (MM/DD/YYYY) _____ Sex: ☐ Male ☐ Female

Phone number: _____ Alternate Phone Number (Optional): _____

Email (Optional): _____

I consent to SFHP Care Plus, directly or through third parties acting on its behalf, contacting me about health plan coverage benefits, health care options or services, health education, or any other member-related topic. I understand these messages may be sent to me by text messages, emails, or phone calls to my cell phone, including automated phone calls delivering pre-recorded messages.

☐ Yes ☐ No

You can change your communications preferences at any time by calling Customer Service.

Permanent residence street address (Don't enter a PO Box): _____

City: _____ County: _____ State: _____ Zip: _____

Mailing address, if different from your permanent address (PO Box allowed):

Street address: _____ City: _____ State: _____ Zip: _____

Your Medicare information

Medicare Number: _____

Part A – Hospital Effective Date: _____

Part B – Medical Effective Date: _____

Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to SFHP Care Plus?

☐ Yes ☐ No

Name of other coverage: _____

Member number for this coverage: _____

Group number for this coverage: _____

Dual-Eligible Special Needs (HMO D-SNP) plans are for those who qualify for Medicare and Medicaid. By enrolling in this plan, you understand that you must remain enrolled in your state Medicaid program to remain eligible for this plan.

1) Are you enrolled in your state Medicaid (Medi-Cal) program? ☐ Yes ☐ No

2) If "yes," provide your Medicaid nine-digit Client Index Number (CIN): _____

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IMPORTANT. Read and sign below.

I must keep both Hospital (Part A) and Medical (Part B) to stay in SFHP Care Plus.

- By joining this Medicare Advantage Plan, I acknowledge that SFHP Care Plus 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 SFHP Care Plus coverage begins, I must get all of my medical and prescription drug benefits from SFHP Care Plus. Benefits and services provided by SFHP Care Plus and contained in my SFHP Care Plus “Member Handbook” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor SFHP Care Plus 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: _____

Date: _____

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

Name: _____

Address: _____

Phone number: _____

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, Cuban |
| ☐ Yes, Puerto Rican | ☐ Yes, another Hispanic, Latino/a, or Spanish origin |
| ☐ Yes, Mexican, Mexican American, Chicano/a | ☐ I choose not to answer |

What's your race? Select all that apply.

- | | |
|---|--|
| ☐ American Indian or Alaska Native | ☐ Black or African American |
| ☐ Asian: | ☐ Native Hawaiian and Pacific Islander: |
| ☐ Asian Indian | ☐ Guamanian or Chamorro |
| ☐ Chinese | ☐ Native Hawaiian |
| ☐ Filipino | ☐ Samoan |
| ☐ Japanese | ☐ Other Pacific Islander |
| ☐ Korean | ☐ White |
| ☐ Vietnamese | ☐ I choose not to answer |

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

- ☐ Chinese ☐ Spanish ☐ Vietnamese ☐ Russian ☐ Tagalog

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

- ☐ Large Print ☐ Braille ☐ County Support ☐ Encrypted Audio CD ☐ Encrypted Data CD
- ☐ Audio Electronic (not encrypted) ☐ Data Electronic (not encrypted)

Please contact SFHP Care Plus at **1(415) 988-8500** or **1(844) 254-8500** (toll-free) if you need information in an accessible format other than what's listed above. From October through March our Medicare Specialists are available every day 8:00am–8:00pm. From April through September we're available Monday–Friday 8:00am–8:00pm. 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: _____

Coverage Information

Proposed Effective Date of Coverage: _____

Election Period: ☐ IEP/ICEP ☐ AEP ☐ SEP ☐ OEPI

SFHP Care Plus (HMO D-SNP) Enrollment Form

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) _____

Optional space for other administrative information needed by plan:

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. 09-700588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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. Because this is a Dual Eligible Special Needs Plan (D-SNP), eligible members may enroll any time of year under the Integrated Care Special Enrollment Period (SEP).

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 enrolling in a Medicare Advantage D-SNP plan as part of a Special Enrollment Period (SEP).
- ☐ 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 recently was released from incarceration. I was released on (insert date) _____

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- ☐ 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 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.

If none of these statements apply to you or you're not sure, please contact SFHP Care Plus at **1(415) 988-8500** or **1(844) 254-8500** (toll-free). From October through March our Medicare Specialists are available every day 8:00am–8:00pm. From April through September we're available Monday–Friday 8:00am–8:00pm. TTY users can call **711**. Visit us at **sfhp.org**.

SFHP Care Plus (HMO D-SNP) is an HMO plan with a Medicare and Medi-Cal contract. Enrollment in SFHP Care Plus depends on contract renewal.