OMB No: 0938-1378
Expires: 7/31/2024

Individual Enrollment Request Form to Enroll in a MedMutual Advantage® Plan

Central Ohio, Cincinnati/Dayton and Toledo Counties

Brown, Butler, Clark, Clermont, Delaware, Fairfield, Franklin, Fulton, Greene, Hamilton, Hancock, Hocking, Licking, Lucas, Madison, Marion, Miami, Montgomery, Morgan, Morrow, Muskingum, Perry, Pickaway, Seneca, Union, Warren, Wood and Wyandot

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:

Medical Mutual
P.O. Box 94563
Cleveland, OH 44101

or you may fax to:
1-800-542-2583

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

How do I get help with this form?

Call Medical Mutual at 1-866-406-8777. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

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.

En español: Llame a Medical Mutual al 1-866-406-8777/711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

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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 this information is incorrect, you may be disenrolled.

- ☐ I am enrolling during the Annual Enrollment Period (AEP) from October 15 to December 7.
- ☐ 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) from January 1 to March 31.
- ☐ 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) _____/_____/_____.
- ☐ 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 _____/_____/_____.
- ☐ 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 coverage). 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 an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- ☐ I'm joining a plan with a 5-Star Special Enrollment Period.

If none of these statements apply to you or you're not sure, please contact Medical Mutual at 1-800-982-3117 (TTY 711 for hearing impaired) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays).

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

Select the plan you want to join. All plans include prescription drug coverage.

- ☐ **MedMutual Advantage Classic HMO –** $0 per month
  - ☐ Add Optional Supplemental Benefits Package to this plan for an additional $34 per month
- ☐ **MedMutual Advantage Secure HMO –** $30 per month
  - ☐ Add Optional Supplemental Benefits Package to this plan for an additional $34 per month
- ☐ **MedMutual Advantage Choice HMO –** $40 per month
  - ☐ Add Optional Supplemental Benefits Package to this plan for an additional $34 per month
- ☐ **MedMutual Advantage Plus HMO –** $97 per month
  - ☐ Add Optional Supplemental Benefits Package to this plan for an additional $34 per month
- ☐ **MedMutual Advantage Select PPO –** $50 per month
  - ☐ Add Optional Supplemental Benefits Package to this plan for an additional $34 per month
- ☐ **MedMutual Advantage Preferred PPO –** $80 per month
  - ☐ Add Optional Supplemental Benefits Package to this plan for an additional $34 per month
- ☐ **MedMutual Advantage Premium PPO –** $136 per month

Please Note: Members can elect to receive the Optional Supplemental Benefits Package at the time of enrollment in a MedMutual Advantage plan or within 30 days of the effective date with our plan. After the first month of coverage, existing members will have the option to elect optional coverage annually during the Annual Enrollment Period (October 15 through December 7).

First Name	Last Name	Middle Initial

Birthdate (MM/DD/YYYY)	Sex ☐ Male ☐ Female	Optional: Email Address*

Home Phone Number ( ) –	Cell Phone Number ( ) –

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

City	State	ZIP Code	County

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

Street Address

City	State	ZIP Code

Your Medicare Information

Medicare Number
__ __ __ __ __ – __ __ __ __ – __ __ __

Answer These Important Questions

☐ **Yes** ☐ **No** Will you have other prescription drug coverage (like VA, TRICARE) in addition to MedMutual Advantage?

Name of Other Coverage	Member Number for this Coverage	Group Number for this Coverage

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IMPORTANT: Read and Sign Below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in MedMutual Advantage.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Medical Mutual 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 on page 6). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can only be enrolled in one MA plan at a time - and that enrollment in this plan will automatically end my enrollment in another plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my MedMutual Advantage coverage begins, I must get all of my medical and prescription drug benefits from Medical Mutual. Benefits and services provided by MedMutual Advantage and contained in my MedMutual Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Medical Mutual 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 I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  – This person is authorized under State law to complete this enrollment, and
  – Documentation of this authority is available upon request by Medicare.

Proxy: I appoint the Secretary of Medical Mutual of Ohio as my proxy to act for me at any annual or special meeting of the members of Medical Mutual of Ohio. The Secretary will act as fully and to the same extent that I could act if personally present at the meeting. This proxy will be in effect for 10 years from the date of my signature below or the effective date of my coverage, whichever date is later. This proxy may be taken back at any time by mailing a letter to the Secretary.

Email Address: I understand if I have included my email address in this application, I am authorizing Medical Mutual to send me an email confirming they received my application.

Signature	**Today's Date**

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

Name	Address
Phone Number ( ) –	
Relationship to Enrollee	

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Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you do not 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
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer**

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

☐ _____

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

☐ Braille ☐ Large print ☐ Audio CD

Please contact Medical Mutual at 1-800-982-3117 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays). 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

Physician Name	Physician Phone Number ( ) –	Physician NPI Number

Paying Your Plan Premiums

You can pay your monthly plan premium (including any late enrollment penalty you currently have or may owe) by mail or Electronic Funds Transfer (EFT) 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 Medical Mutual the Part D-IRMAA.

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Paying Your Plan Premiums

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

☐ **Get a bill**

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check**

I get monthly benefits from: ☐ Social Security ☐ Railroad Retirement Board (RRB)

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.

☐ **Electronic Funds Transfer (EFT) from your bank account each month**

Please enclose a voided check or provide the following information:

Account Type

☐ Checking Account

☐ Savings Account

Bank Routing Number

Bank Account Number

Account Holder's Name

The following section should be completed only by the insurance agent/broker assisting with this application.

Agent/Broker Use Only (If applicable)

Agent/Broker's Name (Please print)	
Date Application Received by Agent/Broker	National Producer Number (NPN)

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.

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.

MedMutual Advantage plans are HMO and PPO plans offered by Medical Mutual of Ohio with a Medicare contract. Enrollment in a MedMutual Advantage plan depends on contract renewal.