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

Individual Enrollment Request Form to Enroll in a MedMutual Advantage Plan

Region 3 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, 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

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.

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 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 Medical Mutual at 1-866-406-8777 (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 $22 per month
- ☐ **MedMutual Advantage Signature HMO** ($0 per month)
  - ☐ Add Optional Supplemental Benefits Package to this plan for an additional $22 per month
- ☐ **MedMutual Advantage Secure HMO** ($28 per month)
  - ☐ Add Optional Supplemental Benefits Package to this plan for an additional $22 per month
- ☐ **MedMutual Advantage Choice HMO** ($34 per month)
  - ☐ Add Optional Supplemental Benefits Package to this plan for an additional $22 per month
- ☐ **MedMutual Advantage Plus HMO** ($95 per month)
  - ☐ Add Optional Supplemental Benefits Package to this plan for an additional $22 per month
- ☐ **MedMutual Advantage Select PPO** ($44 per month)
  - ☐ Add Optional Supplemental Benefits Package to this plan for an additional $22 per month
- ☐ **MedMutual Advantage Preferred PPO** ($75 per month)
  - ☐ Add Optional Supplemental Benefits Package to this plan for an additional $22 per month
- ☐ **MedMutual Advantage Premium PPO** ($128 per month)

Please Note: The Optional Supplemental Benefits Package is not available to add to MedMutual Advantage Premium PPO, as this plan already includes extra vision and dental benefits.

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

__ __ __ __ – __ __ __ – __ __ __ __

*Please Note: By providing your email address, you are giving Medical Mutual permission to send you an email message (e.g., confirming we received your application and/or information about how to opt in to receive additional plan-related email communications).

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.
- 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 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.
- 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 it received my application and/or information about how to opt in to receive additional email communications. All other communications, including whether or not my application was approved for coverage will be sent by mail to the permanent address or mailing address I provided in Section 2. Medical Mutual will not sell my email information and will only send me email communications that I agree to receive by email.

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.

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 1-866-406-8777 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.

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 — Bank Routing Number — Bank Account Number

☐ Checking Account

☐ Savings Account

Account Holder's Name _____

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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)

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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.

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