Individual Enrollment Request to Enroll in a Medicare Advantage Plan with Prescription Drug Coverage

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:
MyTruAdvantage
P.O. Box 428
Columbus, IN 47202

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

How do I get help with this form?
Call MyTruAdvantage at 1-833-213-6731. 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 MyTruAdvantage al 1-844-425-4280/TTY 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.

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.

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 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 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 (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 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.

If none of these statements applies to you or you're not sure. Please contact MyTruAdvantage at 1-833-213-6731 (TTY: 711) to see if you are eligible to enroll.

Hours are 8:00am – 8:00 p.m., local time, 7 days a week. On Thanksgiving and Christmas Day, and weekends and holidays from April 1 through September 30 alternate technologies (for example, voicemail) will be used and we will return your call within (1) business day.

Section 1 – All fields on this page are required (unless marked optional)			
Select the plan you want to join: Effective date of Coverage: ___ /01/2023 ☐MyTruAdvantage Select (HMO)-$0 per month ☐MyTruAdvantage Choice (PPO) - $0 per month ☐MyTruAdvantage Select Plus (HMO)-$0 per month ☐MyTruAdvantage Choice Plus (PPO) - $0 per month			
FIRST name:	LAST name:	Middle Initial (Optional):	
Birth date: (MM/DD/YYYY) (__ __ /__ __ / __ __ __ __)	Sex: ☐Male ☐Female	Phone number: ( )	
Permanent Residence street address (Don't enter a PO Box):			
City:	(Optional) County:	State:	ZIP Code:
Mailing address, if different from your permanent address (PO Box allowed): Street address: _____ City: _____ State: _____ ZIP Code: _____			
Email address: (optional) _____			
Your Medicare information:			
Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __ Effective Dates: Part A__/__/____ Part B __/__/____			
Answer these important questions:			
Will you have other prescription drug coverage (like VA, TRICARE) in addition to MyTruAdvantage: ☐Yes ☐No Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage: _____			
IMPORTANT: Read and sign below:			

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

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, Mexican, Mexican American, Chicano/a
☐Yes, Puerto Rican
☐Yes, Cuban
☐Yes, another Hispanic, Latino/a, or Spanish origin
☐**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**

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

☐Spanish
☐Other: _____

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

☐Braille
☐Large Print

Please contact MyTruAdvantage at 1-833-213-6731 (TTY: 711) if you need information in an accessible format other than what's listed above. Our office hours are 8:00 a.m. - 8:00 p.m., local time, 7 days a week. On Thanksgiving and Christmas Day, and weekends and holidays from April 1 through September 30 alternate technologies (for example, voicemail) will be used and we will return your call within one (1) business day.

Do you work and have health insurance? ☐Yes ☐ No Does your spouse work and provide you with health insurance? ☐Yes ☐ No Name of other health coverage:_____

List your Primary Care Physician (PCP):_____

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

☐Evidence of Coverage
☐Pharmacy Directory
☐Provider Directory
☐Formulary (Drug List)
☐Member Updates (i.e. Newsletters)

Paying a Late Enrollment Penalty (LEP)

If you have a LEP or are assigned one by Medicare, you can pay it by mail or Electronic Funds Transfer (EFT) each month. **You can also choose to pay your LEP by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

Agent Name _____ NPI#_____

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.

MyTruAdvantage is a Medicare Advantage organization with a Medicare contract. Enrollment in MyTruAdvantage plans depends on contract renewal. MyTruAdvantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.844.425.4280 (TTY: 711) 注意：如果您使用繁體中文，您可以免費獲得語 言援助服務。請致電 1.844.425.4280 (TTY: 711).

Optional Supplemental Dental Package – 2023 (*Only required if choosing Optional Dental Coverage*)

If you are approved as a member of MyTruAdvantage Medicare Advantage (MA) plan, you can add optional dental coverage. This benefit must be chosen within 60 days of the effective date for the MyTruAdvantage Medicare plan. (This option is in addition to the standard dental benefits offered with your plan and has a separate maximum benefit amount.)

Note: There is an additional monthly premium of $25.00 for this Optional Dental Coverage.

Please Read and Sign Below

By completing this enrollment application, I agree to the following: This is an optional benefit offered by MyTruAdvantage, which has a contract with the federal government. I understand that in order to enroll in this optional benefit I must have a MyTruAdvantage Medicare plan. I also understand my enrollment in this optional benefit is voluntary and is not required for me to keep my MyTruAdvantage Medicare plan.

I understand that if MyTruAdvantage has not received my plan premium by the first of the month, they may send a notice letting me know that my membership in the plan may end if they do not receive my premium in full within 90 calendar days.

I understand that the dental services included in the package are offered through Delta Dental. Benefit/coverage details, the amount you pay when using participating and non-participating providers, limits/exclusions, etc. can be found online in the Delta Dental Member Handbook at *www.MyTruAdvantage.com*.

Please contact Member Services for instructions on how to disenroll. This form cannot be used to disenroll from the Optional Supplemental Dental Package.

I agree that I have elected the Optional Supplemental Dental Package. I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this enrollment form means that I have read and understand the contents of this enrollment form.

Signature:_____ Today's Date:_____

If you are the authorized representative, you must sign above and provide the following information:
Name: _____
Address: _____
Phone Number: _____

Relationship to enrollee:_____