Massachusetts Individual Enrollment Form

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:
eternalHealth
PO Box 1375
Westborough, MA 01581

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

HOW DO I GET HELP WITH THIS FORM?

Call eternalHealth at 1(800) 893-9457 TTY users can call 711.

Or, call Medicare at 1-800 MEDICARE (1-800-633-4227). 24 hours a day/7 days a week TTY users can call 1-877-486-2048.

En español: Llame a eternalHealth al 1-800-893-9457/TTY 711 o a Medicare gratis al 1-800-633-4227/TTY 1-877-486-2048 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.

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

Select the plan you want to join:

☐ eternalHealth Freedom PPO $0 per month
☐ eternalHealth Forever HMO $0 per month
☐ eternalHealth Give Back PPO $0 per month
☐ eternalHealth ForeverMore HMO $25.00 per month

First Name:	**M.I.:** (optional)	**Last Name:**	**Suffix:**
Birth Date: (MM/DD/YYYY)	**Sex:** ☐ Male ☐ Female	**Phone Number:** (_ _ _) - _ _ _ - _ _ _ _	

Permanent Residence:

Street Address (Don't enter P.O. Box):

City:	**County (optional):**	**State:**	**ZIP Code:**

Mailing Address, if different from your permanent address (P.O. Box Allowed)

Street Address:

City:	**State:**	**ZIP Code:**

Email Address (optional):

Emergency Contact Name:	**Emergency Contact Phone:** (_ _ _) - _ _ _ - _ _ _ _	**Relationship to You:**

Your Medicare Information:

Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to eternalHealth? ☐ 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 eternalHealth.
- By joining this Medicare Advantage Plan, I acknowledge that eternalHealth 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.
- 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 eternalHealth coverage begins, I must get all of my medical and prescription drug benefits from eternalHealth. Benefits and services provided by eternalHealth and contained in my eternalHealth "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor eternalHealth 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 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 ☐ Portuguese ☐ French ☐ French-Creole ☐ Chinese

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

☐ Large Print ☐ Braille ☐ Audio CD

Please contact eternalHealth at 1-800-893-9457 if you need information in an accessible format other than what's listed above. Our office hours are from October 1st to March 31st from 8 a.m. to 8 p.m. local time, 7 days a week and from April 1st to September 30th from 8 a.m. to 8 p.m. local time, Monday through Friday. TTY users can call 711.

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

List your Primary Care Physician (PCP).

Name: **PCP ID:**

Are you an existing member of this PCP? ☐ Yes ☐ No **Medical Group:**

Paying Your Plan Premiums

You can pay your monthly plan premium (including any late enrollment penalty that 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 don't select a payment option, you will get a bill each month.

Please select a premium payment option:

- ☐ Get a bill monthly.
- ☐ Electronic Funds Transfer (EFT) from your bank account each month.
  Please enclose a VOIDED check or provide the following information:
  Account Holder Name: _____ Bank Routing Number: _____
  Account Type: ☐ Checking ☐ Savings Bank Account Number: _____
- ☐ Automatic deduction from your monthly Social Security or Railroad Retired Board (RRB) benefit check:
  - ☐ Social Security benefit check, or
  - ☐ Railroad Retired Board (RRB) benefit check

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 eternalHealth the Part D-IRMAA.

OFFICE USE ONLY		
Name of Staff Member/Agent/Broker (if assisted in enrollment):		
Effective Date: (MM/DD/YYYY)	**Agent Signature:**	**Agent Received Date:**
Agency of Agent:		
Agent First Name:	**Agent Last Name:**	
Agent ID#:		
Online/Telephone Application Confirmation #:		
Date Received:	**Member ID #** _ _ _ _ _ _ _ _ _ - 0 1	

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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OMB No. 0938-1378
Expires:07/31/2024
M1.1.01.1

INFORMATION TO INCLUDE WITH ENROLLMENT MECHANISM

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 eternalHealth at 1 (800) 893-9457 (TTY users should call 711) to see if you are eligible to enroll. We are open October 1 - March 31, seven Days a week, 8 a.m. to 8 p.m, local time and April 1 - September 30, Monday through Friday 8 a.m. to 8 p.m, local time.

OFFICE USE ONLY		
Enrollee First Name:	**Enrollee Last Name:**	**MI:**
Medicare Beneficiary Identifier (MBI):		

OMB No. 0938-1378
Expires:07/31/2024
M1.1.01.1

eternalHealth

AGENT NEEDS ASSESSMENT

Name: _____ Date of Birth: _____ Sex: □ Male □ Female

Stated Height: _____Feet _____inches Stated Weight: _____lbs Primary Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Email address: _____ Is it okay to communicate with you via email? Y □ N □

Home Phone: _____ Cell: _____ Is it okay for us to text or leave voicemail? Y □ N □

GENERAL QUESTIONS:

In general, how would you rate your health? □ Excellent □ Very Good □ Good □ Fair □ Poor

Do you live alone? □ Y □ N Are you homebound? □ Y □ N Do you have a caregiver? □ Y □ N

Do you have a PCP that you see regularly? □ Y □ N If yes PCP Name: _____

Do you have a Power of Attorney (POA) or healthcare surrogate? □ Y □ N □ Not sure

How would you rate your dental Health? □ Excellent □ Very Good □ Good □ Fair □ Poor

Dentist: _____ Last visit? _____

Do you have special DME equipment/supplies? (Walker, Oxygen, CPAP, Urinary Supplies? □ Y_____ □ N

MEDICAL HISTORY INFORMATION:

□ Chronic alcohol & other drug dependence □ Autoimmune disorders □ Cancer □ Dementia

□ Cardiovascular Disorders □ Chronic Heart Failure (CHF) □ Diabetes □ End Stage Liver Disease (ESRD)

□ Hematologic Disorders □ HIV/AIDS □ Chronic Lung Disorders □ Neurological Disorders □ Stroke

□ Chronic and disabling Mental Health Conditions □ Other: _____

MEDICATION INFORMATION: (use back for additional information)

MEDICATION NAME

Needs Assessment Completed by Agent: _____ Date: _____

If filled out by an individual other than member: Name: _____ Relationship: _____
Was member present? □ Y □ N

H Number: _____ NPN: _____ MBI: _____