

MODEL INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN (MAPD)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Prescription Drug Plan (MAPD).

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 Prescription Drug Plan, you must also have either, or 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](https://www.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.

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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.

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:
Valor Health Plan
P.O. Box 527
North Canton, Ohio 44720

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

How do I get help with this form?

Call Valor Health Plan at 1-800-485-3793.
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 Valor Health Plan al

1-800-485-3793/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.

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

Select the plan you want to join:

Valor Health Plan (H1119-001) – \$40.90 per month

FIRST name: LAST name: Optional: Middle Initial:

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:

Your Medicare information:

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

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Valor Health Plan?

Yes No

Name of other coverage: Member number for this coverage: Group number for this coverage:

Are you enrolled in your State Medicaid program? Yes No

If "yes": Medicaid Number _____

Are you a resident in a long-term care facility, such as a nursing home? Yes No

If "yes": Name of Institution _____

IMPORTANT: Read and sign below:

- I must keep hospital (Part A) or Medical (Part B) to stay in Valor Health Plan
- By joining this Medicare Advantage Prescription Drug Plan (MAPD), I acknowledge that Valor Health Plan 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 MAPD plan at a time – and that enrollment in this plan will automatically end my enrollment in another MAPD plan.
- I understand that when my Valor Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Valor Health Plan. Benefits and services provided by Valor Health Plan and contained in my Valor Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Valor Health Plan 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: 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.

- | | |
|---|--|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican | <input type="checkbox"/> Yes, Cuban |
| <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin | |
| <input type="checkbox"/> I choose not to answer. | |

What's your race? Select all that apply.

- | | | |
|---|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Black or African American |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Filipino | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Other Asian | <input type="checkbox"/> Other Pacific Islander | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Vietnamese | <input type="checkbox"/> White | |
| <input type="checkbox"/> I choose not to answer. | | |

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

- (Language requested _____)

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

- Braille Large print Audio CD

Please contact Valor Health Plan at 1-800-485-3793 if you need information in an accessible format other than what's listed above. Our office hours are 8:00 a.m. to 8:00 p.m. 7 days a week. 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:

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

- | | |
|--|---|
| <input type="checkbox"/> Evidence of Coverage | <input type="checkbox"/> List of providers (Provider Directory) |
| <input type="checkbox"/> List of pharmacies (Pharmacy Directory) | <input type="checkbox"/> List of covered drugs (Formulary) |

Email address: _____

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 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.**

- Get a bill
 Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB)

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 Valor Health Plan the Part D-IRMAA.

Office Use Only:	
Application Received Date	
Application System Entry Date	
Effective Date of Coverage	
Plan ID#	
Election Period	
Agent/Broker	

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 1860D-1 of the Social Security Act and 42 CFR §§ 423.30 and 423.32 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.

**Valor Health Plan is an HMO (I-SNP) with a Medicare contract.
Enrollment in Valor Health Plan depends on contract renewal.**

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