OMB No. 0938-1378
Expires: 6/30/2026

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 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:
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) – $39.30 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. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

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.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer**
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native Asian
  - ☐ Asian Indian
  - ☐ Chinese
  - ☐ Filipino
  - ☐ Japanese
  - ☐ Korean
  - ☐ Vietnamese
  - ☐ Other Asian
- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ White
- ☐ **I choose not to answer**

What is your gender? Select one:

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____
- ☐ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ **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.

☐ Evidence if Coverage ☐ List of providers (Provider Directory)

☐ List of pharmacies (Pharmacy Directory) ☐ 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.

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third-parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee _____

Signature _____ National Producer Number (Agents/Brokers only):_____

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.