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

AMERICAN HEALTH ADVANTAGE OF PENNSYLVANIA

Individual Enrollment Request 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
- Be a resident in an American Health Advantage of Pennsylvania contracted nursing home facility
- - or - live at home and the plan has obtained certification that you need the type of care that is usually provided in a nursing home.

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 monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to: American Health Advantage of Pennsylvania
201 Jordan Rd, Suite 200
Franklin, TN 37067

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

How do I get help with this form?

Call American Health Advantage of Pennsylvania at 1-855-239-1022. TTY users can call 1-833-312-0046.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En Español: Llame a American Health Advantage of Pennsylvania al 1-855-239-1022/TTY 1-833-312-0046 o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

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.

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

Select the plan you want to join:

☐ American Health Advantage of Pennsylvania (HMO I-SNP) [H9909-001] – $48.40 per month

First name:_____ Middle initial: _____ Last name: _____
Birth date: (MM/DD/YYYY) (__ __ /__ __ / __ __ __ __) Sex: __ Male __ Female
Phone number: (_____) _____ - _____

Permanent residence street address (please do not enter a P.O. box)
Street: _____
City: _____ State: _____ Zip code: _____County: _____

Mailing address, *if different from your permanent address* (P.O. box allowed)
Street: _____
City: _____ State: _____ Zip code: _____County: _____

Your Medicare information

Medicare number: ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to American Health Advantage of Pennsylvania? ☐ Yes ☐ No
Name of other coverage: _____
Member number for this coverage: _____ Group number for this coverage:_____

Do you reside at home or in an assisted living facility? ☐ Yes ☐ No
If *yes*, has the state that you reside in certified that you need the type of care that is usually provided in a nursing home? ☐ Yes ☐ No

Are you a resident of or expect to be a resident of a long-term care facility or an assisted living facility in the American Health Advantage of Pennsylvania network for more than 90 days? ☐ Yes ☐ No
If *yes,* please provide the following information:
Name of facility: _____
Facility address: _____
City: _____ State: _____ Zip code: _____County: _____

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IMPORTANT: Read and sign below

• I must keep both Hospital (Part A) and Medical (Part B) to stay in American Health Advantage of Pennsylvania.
• By joining this Medicare Advantage Plan, I acknowledge that American Health Advantage of Pennsylvania 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 American Health Advantage of Pennsylvania coverage begins, I must get all of my medical and prescription drug benefits from American Health Advantage of Pennsylvania. Benefits and services provided by American Health Advantage of Pennsylvania and contained in my American Health Advantage of Pennsylvania "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor AAmerican Health Advantage of Pennsylvania 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 are the authorized representative, sign above and fill out the fields below:

Name: _____

Street address: _____

City: _____ State: _____ Zip code: _____County: _____

Phone number: (_____) _____ - _____ Relationship to enrollee: _____

Office use only

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID#: _____ Effective date of coverage: _____ / _____ / _____

ICEP/IEP: _____ AEP:_____ SEP (type):_____ Not eligible: _____

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
- ☐ Chinese
- ☐ Japanese
- ☐ Other Asian
- ☐ Vietnamese
- ☐ **I choose not to answer.**
- ☐ Asian Indian
- ☐ Filipino
- ☐ Korean
- ☐ Other Pacific Islander
- ☐ White
- ☐ Black or African American
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan

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 don't know ☐ **I choose not to answer**

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

☐ Large print ☐ Audio CD ☐ Data CD ☐ Braille

Please contact American Health Advantage of Pennsylvania at 1-855-239-1022 if you need information in an accessible format other than what's listed above. Our office hours are October 1 - March 31: 8:00 am - 8:00 pm, seven days a week. April 1 - September 30: 8:00 am - 8:00 pm, Monday - Friday. *TTY users can call 1-833-312-0046.*

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

List your primary care physician (PCP), clinic, or health center:

_____

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.**

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 American Health Advantage of Pennsylvania the Part D-IRMAA.

Please select a premium payment option:

- ☐ Get a bill each month
- ☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security 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.)

If a premium payment option is not selected above, the default action will be direct bill.

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): _____

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 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. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.