Enrollment Form

KeyCare ADVANTAGE

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 monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?
Send your completed and signed form to:
KeyCare Advantage
P.O. Box 607
Glen Burnie, MD 21060-0607
Once they process your request to join, they'll contact you.

How do I get help with this form?
Call KeyCare Advantage at 1-844-206-1205 (TTY 711).

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

En español: Llame a KeyCare Advantage al 1-844-206-1205 (TTY 711) o a Medicare gratis al 1-800-633-4227 y oprima el 8 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.

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.

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SECTION 1: To enroll, all fields in this section are required (unless marked optional)

Please check which plan you want to enroll in:

☐ KeyCare Advantage (HMO I-SNP) - $0.00 per month
☐ KeyCare Advantage Plus (HMO C-SNP) - $0.00 per month

Applicant Information: ☐ Male ☐ Female

☐ Mr. ☐ Mrs. ☐ Ms. Birth Date (MM/DD/YYYY): (_____/_____/_____)

First Name _____ Last Name _____ M.I. ___

Medicare Number (MBI)_____

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1. Will you have other prescription drug coverage in addition to KeyCare Advantage? ☐ Yes ☐ No

   IF YES, please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other drug coverage _____

   Member number for this coverage _____

   Group number for this coverage _____

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance program.

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SECTION 1 (continued): To enroll, all fields in this section are required (unless marked optional)

2. Are you a resident of or expect to be a resident of a long-term care facility (LTC) or an assisted living facility (ALF) in the KeyCare Advantage network for more than 90 days?
☐ Yes ☐ No

IF YES, please fill out the facility information below:

Name of Facility _____

Street Address _____

City _____ State _____ Zip _____

Phone Number of Facility _____

C-SNP ONLY (If you are enrolling in the C-SNP, please fill out this question)

3. Does the applicant have a diagnosis of chronic heart failure? ☐ Yes ☐ No

4. Does the applicant have a diagnosis of diabetes? ☐ Yes ☐ No

5. Does the applicant have a diagnosis of cardiovascular disorder(s)? ☐ Yes ☐ No

6. Who helped you complete this application?

☐ Agent NPN#_____ ☐ SHIP Counselor ☐ Other (Third Party)

☐ Broker ☐ Authorized Representative ☐ Self

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SECTION 1 (continued): To enroll, all fields in this section are required (unless marked optional)

IMPORTANT: Read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in KeyCare Advantage.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that KeyCare Advantage 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).
- 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 when my KeyCare Advantage coverage begins, I must get all of my medical and prescription drug benefits from KeyCare Advantage. Benefits and services provided by KeyCare Advantage and contained in my KeyCare Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor KeyCare Advantage 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 of applicant or the responsible party	Today's Date
X	

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SECTION 1 (continued): To enroll, all fields in this section are required (unless marked optional)

Applicant Contact Information:

Permanent Residence Address (P.O. Box not allowed)

Street _____

City _____ State _____ Zip _____

Phone (_____) _____ Cell Phone** (_____) _____

Email* (optional)_____

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

Attn Name _____

Street _____

City _____ State _____ Zip _____

Responsible Party Contact Information (as applicable):
If you're the authorized representative, you must sign previous page and fill out these fields:

First Name _____ Last Name _____

Street _____

City _____ State _____ Zip _____

Relationship to Enrollee _____

Phone ☐ Cell** ☐ Home (_____) _____

Email* (optional) _____

* *By providing your email address, you are opting in to receive electronic communication, when available. If you'd like to opt out of electronic communications, check this box:* ☐ *Opt out*

** *By providing your cell phone number, you are opting in to receive plan communications via SMS/text message. If you do not wish to receive any plan communications or updates via text message, please opt out:* ☐ *Opt out*

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SECTION 2: All fields are optional. Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

1. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

   IF YES, what is your Medicaid number? _____

2. Do you work? ☐ Yes ☐ No

   Does your spouse work? ☐ Yes ☐ No

3. Please choose your in-network Primary Care Physician (PCP):

   Physician Name: _____

   Is this your current physician? ☐ Yes ☐ No

4. In which language would you like to receive your plan information?

   ☐ English ☐ Farsi ☐ French
   ☐ German ☐ Spanish ☐ Vietnamese
   ☐ Other: _____

5. Which format do you need to receive this information?

   ☐ Audio File ☐ Braille ☐ None of the above
   ☐ Large Print ☐ Compact Disc (CD)

Please contact KeyCare Advantage 1-844-206-1205 if you need information in an accessible format or language other than what is listed above. Our office hours are 8:00 am to 8:00 pm local time. TTY users can call (TTY 711).

Paying Your Plan Premium

For plans with a premium, 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.**

☐ Yes, I'd like my premium to be taken out of my Social Security
☐ Yes, I'd like my premium to be taken out of my Railroad Retirement Board (RRB)
☐ No, none of the above; I would like a direct bill
☐ Not applicable

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SECTION 2 (continued): Paying Your Plan Premium

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 KeyCare Advantage the Part D-IRMAA.

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.

KeyCare Advantage is an HMO I-SNP and HMO C-SNP with a Medicare contract. Enrollment in KeyCare Advantage plans depends on contract renewal. Other providers are available in our network. Some plan benefits are part of Special Supplemental Benefits for the Chronically Ill (SSBCI). Not all members qualify. To be eligible, a member must have a qualifying chronic condition, be determined by the plan and a healthcare provider to be at high risk for hospitalization or other adverse health outcomes, and require a high level of care coordination. Even if a member has a qualifying chronic condition, they may not receive these benefits. Coverage depends on the plan's specific eligibility criteria and clinical determination. Members may be required to complete an assessment with the plan's care team to confirm eligiblity throughout the year. For accommodations of persons with special needs at meetings call: 1-844-206-1205 (TTY 711). KeyCare Advantage 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: 1-844-206-1205 (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 1-844-206-1205 (TTY 711). Our hours of operation are 8am – 8pm local time, 7 days a week from October 1st – March 31st, 5 days a week from April 1st – September 30th. Note: Member Services is closed on the following holidays: Memorial Day, Independence Day, Thanksgiving, and Christmas.

OFFICE USE ONLY. Please DO NOT complete unless authorized.

Agent First and Last Name _____

Plan ID _____

Application received date _____ Coverage effective date _____

Select the enrollment period:

☐ IEP/ICEP ☐ AEP ☐ OEPI ☐ SEP (type) _____ ☐ Not eligible

Signature _____ Date _____

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