Community **HealthFirst**™
Medicare Advantage Plans

Offered by COMMUNITY HEALTH PLAN of Washington™

INDIVIDUAL ENROLLMENT FORM

Please open completely
before filling out form.

ENROLLMENT FORM CHECKLIST:

- ☐ Did you select the plan you want to enroll in?
- ☐ Did you select a primary care provider?
- ☐ Did you select a payment method?
- ☐ Did you answer all of the questions?
- ☐ Did you sign and date page 3?

1111 3rd Avenue, Ste 400, Seattle,WA 98101 • Phone: 1-800-944-1247 (TTY Relay: Dial 7-1-1) • Fax: 206-613-5089

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Please contact Community HealthFirst if you need information in another language or another format (Braille).

To Enroll in Community HealthFirst, Please Provide the Following Information

Please check which plan you want to enroll in:

	2018 Premiums
☐ Community HealthFirst MA Special Needs Plan (014) (HMO SNP)	$0.00**
☐ Community HealthFirst MA Plan (006) (HMO)	$30.00
☐ Community HealthFirst MA Pharmacy Plan (008) (HMO)	$67.00
☐ Community HealthFirst MA Pharmacy Plan (009) (HMO)	$93.00
☐ Community HealthFirst MA Extra Plan (010) (HMO)	$20.90

**Premium rate is based upon level of State Medicaid eligiblity.

Name of chosen Primary Care Provider (PCP/Clinic) _____

LAST Name:	FIRST Name:	Middle Initial:	Mr. ☐ Mrs. ☐ Ms. ☐

Birth Date: (__ __/ __ __/ __ __ __ __) M M/ D D/ Y Y Y Y	Sex: M ☐ F ☐	Home Phone Number: ( ) -	Alternate Phone Number: ( ) -

Permanent Residence Street Address (P.O. Box is not allowed):		**Email Address**:
City/State:	ZIP Code:	County:

Mailing Address (only if different from your Permanent Residence Street Address):

City/State:	ZIP Code:	County:	ProviderOne Number:

Emergency Contact Name:	Emergency Contact Number: ( ) -

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

Fill out this information as it appears on your Medicare card.

- OR -

Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

Is Entitled To: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

PLAN USE ONLY: ☐ICEP/IEP ☐AEP ☐SEP/LIS ☐SEP/MOVED ☐SEP (List Type) ☐Not Eligible

Agent Number	Territory Agent Number	Date Received	Date Entered	Proposed Effective Date

Paying Your Plan Premium

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 automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay Community HealthFirst the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Get a bill and pay by personal check on a monthly basis.

☐ Electronic Funds Transfer (EFT) from your bank account each month—**Please enclose a VOIDED check or provide the following:**

Account holder name: _____

Bank routing number: _ _ _ _ _ _ _ _ _ Bank account number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Account type: ☐ Checking ☐ Savings

☐ 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/RRB 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.)

Please Read and Answer These Important Questions

1. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No

If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

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

Will you have other prescription drug coverage in addition to Community HealthFirst? ☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

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

If "yes," please provide the following information: Name of Institution: _____

Address & Phone Number of Institution (number & street):_____

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

If "yes," please provide your Medicaid number: _____

5. Do you or your spouse work? ☐ Yes ☐ No

Please check the box if you would prefer us to send you information in a language other than English or another format: ☐ Spanish ☐ Braille ☐ Large Print

Please contact Community HealthFirst at 1-800-944-1247 (TTY Relay: Dial 7-1-1) if you need information in another format or language than what is listed above. Our office hours are 8:00 a.m. – 8:00 p.m., 7 days a week.

STOP! Please Read This Important Information and Sign Below

If you currently have health coverage from an employer or union, joining Community HealthFirst could affect your employer or union health benefits. You could lose your employer or union health coverage if you join a Community HealthFirst Medicare Advantage Plan. Read the communications your employer or union sends you. If you have questions, visit their website or contact the office listed in their communications. If there isn't any information on who to contact, your benefits administrator or the office that answers questions about your coverage can help.

By completing this enrollment application, I agree to the following:

Community HealthFirst is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15-December 7 of every year), or under certain special circumstances.

Community HealthFirst serves a specific service area. If I move out of the area that Community HealthFirst serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Community HealthFirst, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Community HealthFirst when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Community HealthFirst coverage begins, I must get all my health care from Community HealthFirst, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Community HealthFirst and other services contained in my Community HealthFirst Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR COMMUNITY HEALTHFIRST WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Community HealthFirst, he/she may be paid based on my enrollment in Community HealthFirst.

Release of Information:

By joining this Medicare health plan, I acknowledge that Community HealthFirst will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Community HealthFirst will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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 authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (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 from Medicare.

Your Signature: **X**	**Today's Date:**
If you are the authorized representative, you must provide the following information: Name:_____ Address: _____ **Phone Number:** (_____) _____ – _____ **Relationship to Enrollee:**_____	
Agent Signature (if assisted with enrollment):	

Important Information on the Community HealthFirst MA Special Needs Plan (014) service area

Community HealthFirst has designed this plan option specifically to meet the health care needs of people in Washington State who are eligible for both Medicare and Medicaid. If you are eligible or already enrolled in Medicare (Part A & B) and you meet certain Medicaid eligibility requirements, you may choose this option or you may choose any of our other Community HealthFirst Medicare Advantage Plan options. Member is responsible for paying the Part B premium and the Part D premium, which may or may not be covered by a third party such as Medicaid. If you do not meet this criterion, the Community HealthFirst MA Special Needs Plan option is not available to you and you may select from any of our other Community HealthFirst Medicare Advantage plans.

The premium rate listed on page 1 for the Community HealthFirst MA Special Needs Plan applies to people living in the following counties: Adams, Chelan, Clark, Douglas, King, Kitsap, Lewis, Skagit, Spokane, Thurston, Whatcom, and Yakima Counties, WA.

Community Health Plan of Washington is an HMO Plan with a Medicare contract and a contract with the Washington state Medicaid Program. The Community Health Plan of Washington Special Needs Plan (SNP) is available to anyone who has both Medical Assistance from the State and Medicare. Enrollment in Community Health Plan of Washington depends on contract renewal. You must continue to pay your Medicare Part B premium.

Important Information on the Community HealthFirst MA Plan (006) service area

The premium rate listed on page 1 for the Community HealthFirst MA Plan applies to people living in the following counties: Clark, King, and Spokane, WA.

Community Health Plan of Washington is an HMO plan with a Medicare contract. Enrollment in Community Health Plan of Washington depends on contract renewal. You must continue to pay your Medicare Part B premium.

Important Information on the Community HealthFirst MA Pharmacy Plan (008) service area

The premium rate listed on page 1 for the Community HealthFirst MA Pharmacy Plan applies to people living in the following counties: Clark, King, and Spokane, WA.

Community Health Plan of Washington is an HMO plan with a Medicare contract. Enrollment in Community Health Plan of Washington depends on contract renewal. You must continue to pay your Medicare Part B premium.

Important Information on the Community HealthFirst MA Pharmacy Plan (009) service area

The premium rate listed on page 1 for the Community HealthFirst MA Pharmacy Plan applies to people living in the following counties: Adams, Whatcom, and Yakima Counties, WA.

Community Health Plan of Washington is an HMO plan with a Medicare contract. Enrollment in Community Health Plan of Washington depends on contract renewal. You must continue to pay your Medicare Part B premium. This information is available for free in other languages. Please contact our customer service number at 1-800-942-0247 (TTY Relay: Dial 7-1-1), from 8:00 a.m. to 8:00 p.m., 7 days a week for additional information.

Community Health Plan of Washington es un plan de salud HMO que tiene un contrato con Medicare. La inscripción en los planes de Community Health Plan of Washington está sujeta a la renovación del contrato. Es necesario que usted pague su prima de Medicare Parte B. Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro servicio al cliente al número 1-800-942-0247 (TTY Relay: marque 7-1-1), de 8:00 a.m. a 8:00 p.m., los 7 días de la semana para obtener más información.

Important Information on the Community HealthFirst MA Extra Plan (010) service area

The premium rate listed on page 1 for the Community HealthFirst MA Extra Plan applies to people living in the following counties: Clark, King, Spokane, and Yakima Counties, WA.

Community Health Plan of Washington is an HMO plan with a Medicare contract. Enrollment in Community Health Plan of Washington depends on contract renewal. You must continue to pay your Medicare Part B premium.