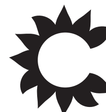
1111 3rd Ave, Ste 400, Seattle,WA 98101 • Phone: 1-800-944-1247 (TTY Relay: Dial 7-1-1) • Fax: 206-613-5089

Community **HealthFirst**™
Medicare Advantage Plans

Offered by  COMMUNITY HEALTH PLAN of Washington™

Plan Change Form

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

Please Provide the Following Information

Please check which plan you want to enroll in.

Plan	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) ______________________________

Name:	Member Number:	Date of Birth:	
Home Phone Number:	ProviderOne Number	Alternative Phone Number:	Email Address:

Permanent Residence Street Address (PO Box not allowed):

City/State:	ZIP Code:	County:

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

City/State:	ZIP Code:	County:

Please fill out the following:

I am currently a member of the ______________________________ plan in Community HealthFirst with a monthly premium of $________________.
I would like to change to the ______________________________ plan in Community HealthFirst.
I understand that this plan has different health benefits and a monthly premium of $________________.

Information in Other Languages

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.

Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail or bank Electronic Funds Transfer (EFT) each month. You can also choose to pay your monthly premium by automatic deduction from your credit or debit card or from your monthly Social Security or Railroad Retirement Board Check.

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 the Railroad Retirement Board. Do NOT pay Community HealthFirst the Part D-IRMAA extra amount.

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

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

Your Plan Premium

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify 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 for this benefit. 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 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 approved 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.)

☐ **Pay online using your credit or debit card.**

I will pay my monthly plan premium directly by using E-Bill Express, an online payment tool. I will sign up on E-Bill Express to make single payments or set up automatic recurring payments from my credit or debit card. For more information or to enroll in this payment option, visit our website at healthfirst.chpw.org/for-members/bill-pay.

Please Read and Sign Below

Community HealthFirst is a Medicare Advantage plan that has a contract with the Federal government.

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 that 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 people with Medicare aren't 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 of my health care services from Community HealthFirst. 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 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 sign and 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.