OMB No. 0938-1378 Expires: 06/30/2026

FHCP Medicare

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

You must complete all items unless they are indicated as optional. You can't be denied coverage for not including information that is marked as optional.

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.

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:

FHCP Medicare
P.O. Box 45296
Jacksonville, FL 32232-5296

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

How do I get help with this form?

Call FHCP Medicare Rx Plus, FHCP Medicare Rx Plus POS, FHCP Medicare Rx Savings or FHCP Medicare Premier Advantage at 1-800-352-9824, Ext. 7160. TTY users can call 1-800-955-8770.

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

En español: Llame a FHCP Medicare Rx Plus, FHCP Medicare Rx Plus POS, FHCP Medicare Rx Savings o FHCP Medicare Premier Advantage al 1-800-352-9824, Ext. 7160 / TTY: 1-800-955-8773 o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

FHCP Medicare

P.O. Box 45296 | Jacksonville, FL 32232-5296

A Medicare Advantage Health Care Plan

Individual Enrollment Form

Please check which plan you want to enroll in:

- ○ **FHCP Medicare Rx Savings** $0 per month
- ○ **FHCP Medicare Rx Plus** <$49> per month
- ○ **FHCP Medicare Premier Advantage** $0 per month
- ○ **FHCP Medicare Rx Plus POS** <$119> per month

First Name: | Last Name: | Middle Initial:

Birth Date:	Sex:	Home Phone Number:	Mobile Phone Number:
M M D D Y Y Y Y	○ M ○ F	( )	( )

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:	County:	State:	ZIP Code:

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

Street Address:	City:	State:	ZIP Code:

By providing the information above, you confirm that you are the subscriber and/or authorized user of the phone numbers provided and you consent to receive calls and text messages at those number(s) from, and on behalf of, Florida Blue Medicare, Inc., DBA FHCP Medicare, its affiliates, including calls and texts using an automated telephone dialing system, prerecorded or artificial voice messages, or both without regard to state or federal limitations on the frequency of calls or messages. The types of calls and texts you consent to receive include messages about your plan and benefits, messages about servicing your accounts, and healthcare related and informational messages that are not for marketing purposes. You may revoke your consent at any time. Message frequency varies. Major carriers supported.

Please provide your Medicare insurance information:

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

Medicare Number:	Part A Effective Date:	Part B Effective Date:
	M M D D Y Y Y Y	M M D D Y Y Y Y

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you of 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
- ○ **I choose not to answer.**
- ○ Non-binary
- ○ I use a different term: _____

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 choose not to answer.**
- ○ I use a different term: _____
- ○ I don't know

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

Language: ○ Spanish

Accessible Format (Select One): ○ Braille ○ Large Print ○ Audio CD ○ Data CD

Please contact FHCP Medicare Rx Plus, FHCP Medicare Rx Plus POS, FHCP Medicare Rx Savings or FHCP Medicare Premier Advantage at 1-800-352-9824, Ext. 7160 if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. – 5 p.m. local time, Monday through Friday. TTY users should call 1-800-955-8770.

Please read and answer these important questions (Questions 2–5 are optional):

1. Will you have other **prescription** drug coverage (like VA, TRICARE) in addition to FHCP Medicare Rx Plus, FHCP Medicare Rx Plus POS, FHCP Medicare Rx Savings or FHCP Medicare Premier Advantage? ○ Yes ○ No

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

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

   Name of Institution: _____ Phone Number: (_____) _____ – _____

   Address (number and street): _____

3. Are you enrolled in your State Medicaid program? ○ Yes ○ No

   Medicaid number: _____

4. Do you or your spouse work? ○ Yes ○ No

5. Please choose the name of a Primary Care Physician (PCP), clinic or health center: _____

Paying Your Plan Premium:

- **For those members enrolling in FHCP Medicare Rx Savings or FHCP Medicare Premier Advantage,** if we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it.
- **For those members enrolling in FHCP Medicare Rx Plus or FHCP Medicare Rx Plus POS,** you can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT), or Credit Card each month. We need to know how you would prefer to pay.

Please select a premium payment option (If you don't select a payment option, you will get a bill each month):

- ○ Get a bill
- ○ Electronic Funds Transfer (EFT) from your bank account each month. (FHCP Medicare will send you a letter with further instructions on how to set this up.)
- ○ Credit Card (FHCP Medicare will send you a letter with further instructions on how to set this up.)
- ○ 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.)

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 FHCP Medicare the Part D-IRMAA.

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ○ I am new to Medicare.
- ○ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ○ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date): |M|M| |D|D| |Y|Y|Y|Y|
- ○ I recently was released from incarceration. I was released on (insert date): |M|M| |D|D| |Y|Y|Y|Y|
- ○ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date): |M|M| |D|D| |Y|Y|Y|Y|
- ○ I recently obtained lawful presence status in the United States. I got this status on (insert date): |M|M| |D|D| |Y|Y|Y|Y|
- ○ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date): |M|M| |D|D| |Y|Y|Y|Y|
- ○ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date): |M|M| |D|D| |Y|Y|Y|Y|
- ○ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ○ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date): |M|M| |D|D| |Y|Y|Y|Y|
- ○ I recently left a PACE program on (insert date): |M|M| |D|D| |Y|Y|Y|Y|
- ○ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date): |M|M| |D|D| |Y|Y|Y|Y|

- ○ I am leaving employer or union coverage on (insert date): M M D D Y Y Y Y
- ○ I belong to a pharmacy assistance program provided by my state.
- ○ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ○ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date): M M D D Y Y Y Y
- ○ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date): M M D D Y Y Y Y
- ○ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- ○ I was enrolled in a plan that is experiencing financial difficulties to such an extent that a State or territorial regulatory authority has placed the organization in receivership.
- ○ I was enrolled in a plan identified with the low performing icon (LPI).

If none of these statements applies to you or you're not sure, please contact FHCP Medicare Rx Plus, FHCP Medicare Rx Plus POS, FHCP Medicare Rx Savings or FHCP Medicare Premier Advantage at 1-800-352-9824, Ext. 7160 (TTY users should call 1-800-955-8770) to see if you are eligible to enroll. We are open 8 a.m. – 5 p.m. local time, Monday through Friday.

Please Read and Sign Below. By completing this enrollment application, I agree to the following:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in FHCP Medicare Rx Plus, FHCP Medicare Rx Plus POS, FHCP Medicare Rx Savings or FHCP Medicare Premier Advantage.
- I understand that my 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 people with Medicare are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.
- I understand that when my FHCP Medicare Rx Plus, FHCP Medicare Rx Plus POS, FHCP Medicare Rx Savings or FHCP Medicare Premier Advantage coverage begins, I must get all of my medical and prescription drug benefits from FHCP Medicare Rx Plus, FHCP Medicare Rx Plus POS, FHCP Medicare Rx Savings or FHCP Medicare Premier Advantage. Benefits and services provided by FHCP Medicare Rx Plus, FHCP Medicare Rx Plus POS, FHCP Medicare Rx Savings or FHCP Medicare Premier Advantage and contained in my FHCP Medicare Rx Plus, FHCP Medicare Rx Plus POS, FHCP Medicare Rx Savings or FHCP Medicare Premier Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor FHCP Medicare Rx Plus, FHCP Medicare Rx Plus POS, FHCP Medicare Rx Savings or FHCP Medicare Premier Advantage will pay for benefits or services that are not covered.
- FHCP Medicare Rx Plus, FHCP Medicare Rx Plus POS, FHCP Medicare Rx Savings or FHCP Medicare Premier Advantage services a specific area. If I move out of the area that FHCP Medicare Rx Plus, FHCP Medicare Rx Plus POS, FHCP Medicare Rx Savings or FHCP Medicare Premier Advantage services, I need to notify the plan so I can disenroll and find a new plan in my area.
- **Release of Information:** By joining this Medicare health plan, I acknowledge that FHCP Medicare Rx Plus, FHCP Medicare Rx Plus POS, FHCP Medicare Rx Savings or FHCP Medicare Premier Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.
- I also acknowledge that FHCP Medicare Rx Plus, FHCP Medicare Rx Plus POS, FHCP Medicare Rx Savings or FHCP Medicare Premier 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).

- I understand that my signature (or the signature of the person legally 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.

Signature: _____ **Today's Date:** M M D D Y Y Y Y

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: (_____) _____ – _____ **Relationship to Enrollee:** _____

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 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.

Email Communications

Email is a great way to stay in touch. Enter your email below to opt-in to receive email messages. By enrolling in paperless communications, you agree to receive messages electronically, which may include but not limited to, the Evidence of Coverage, Summary of Benefits, Notice of Privacy Practices, Proxy Statements, financial matters, and marketing. You understand and acknowledge that electronic communications may not be secure, you are responsible for and accept the risk you agree to accept the risk that electronic communications may be intercepted and/or read by a third party. By agreeing to receive electronic communications you agree to indemnify and hold Florida Blue, DBA FHCP Medicare and its affiliates harmless from any claim or cause of action against Florida Blue, DBA FHCP Medicare and its affiliates for delivering or other information to the address, phone number, or other contact information that you provide.

E-mail: _____

Medicare Prescription Payment Plan Participation (Completion of this section is optional.)

○ Yes, I would like to participate in the Medicare Prescription Payment Plan.

- I understand this section is a request to participate in the Medicare Prescription Payment Plan. FHCP Medicare Rx Plus, FHCP Medicare Rx Plus POS, FHCP Medicare Rx Savings, FHCP Medicare Premier Advantage will contact me if they need more information.
- I understand that signing below means I have read and understand this section and the "Terms and Conditions" below.
- FHCP Medicare Rx Plus, FHCP Medicare Rx Plus POS, FHCP Medicare Rx Savings, FHCP Medicare Premier Advantage will send me a notice to let me know when my participation in the Medicare Prescription Payment Plan is active. Until then, I understand that I'm not a participant in the Medicare Prescription Payment Plan.

Signature: _____

Today's Date: M M D D Y Y Y Y

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: (_____) _____ – _____ **Relationship to Enrollee:** _____

Terms and Conditions

- The program is free to join, there are no fees or interest charged under the program, and the program does not lower the amount of cost-sharing you owe for your Part D prescriptions.
- If you qualify for Low Income Subsidy (LIS), enrollment in LIS is more advantageous than participation in the Medicare Prescription Payment Plan.
- Payments are required to be through Automated Clearing House (ACH) deposits.
- You may opt out of the program at any time. If you opt out, you will still be responsible for paying any remaining balance.
- It is important to pay your bill monthly. Your participation in the Medicare Prescription Payment Plan will be terminated if you fail to pay your monthly billed amount before the end of the grace period.
- If you are disenrolled voluntarily or involuntarily from our Part D plan you will also be terminated from the Medicare Prescription Payment Plan. If you enroll in a different plan, you may opt into the Medicare Prescription Payment Plan under your new plan.
- We cannot require you to answer questions about or provide documentation to prove your ability to pay your Medicare Prescription Payment Plan balance as a condition of you participating in the Medicare Prescription Payment Plan. We also cannot obtain a copy of your credit report from a consumer reporting agency.
- The Part D appeals and grievance procedures will apply to the Medicare Prescription Payment Plan and are located in the Evidence of Coverage.
- For additional information regarding the Medicare Prescription Payment Plan, please contact 1-877-282-2779.

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: _____

PCP Provider ID#: _____

Entity Name:

_____

Five digit Entity ID number (if known):

|_|_|_|_|_|

Date Received by Agent: _____

FHCP Medicare Agent ID #: _____

Agent State License #: _____

Agent Confirmation #: _____