Individual Enrollment Request Form To Enroll In Hamaspik Medicare Select (HMO D-SNP)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug 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.*

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 the next page to send your completed form to the plan.*

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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: *Hamaspik Medicare Select*
775 North Main Street
Spring Valley, NY 10977

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

How do I get help with this form?

Call Hamaspik Medicare Select at 888-426-2774. *TTY users, please call 711.*

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

En español: *Llame a Hamaspik Medicare Select al 888-426-2774. 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.

Hamaspik Medicare SELECT

Section1 – Allfields onthispage are required (unless marked optional)

Select the plan you want to join:

◯ *Hamaspik Medicare Select - $0 per month*

FIRST Name:	*LAST Name:*	*(OPTIONAL) Middle Initial:*
Birth Date: MM / DD / YYYY	*Sex:* ◯ *Male* ◯ *Female*	*Phone Number:*

Permanent Residence Street Address *(Don't enter a P.O. Box. For individuals experiencing homelessness, a P.O.Box may be your permanent residence address.)*

City:	*County:*	*State:*	*Zip Code:*

Mailing address, if different from your permanent address *(P.O. Box is allowed):*

Address:	*City:*	*State:*	*Zip Code:*

Your Medicare Information

Medicare Number:

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Hamaspik Medicare Select?

◯ *Yes* ◯ *No*

Name of Other Coverage:

Member Number of Other Coverage:

Group Number of Other Coverage:

Do you have Medicaid in New York State? ◯ *Yes* ◯ *No*

Hamaspik Medicare SELECT

IMPORTANT:
Read and sign below

- *I must keep both Hospital (Part A) and Medical (Part B) to stay in Hamaspik Medicare Select.*
- *By joining this Medicare Advantage Plan, I acknowledge that Hamaspik Medicare Select 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 and MA MSA plans.)*
- *I understand that when my Hamaspik Medicare Select coverage begins, I must get all of my medical and prescription drug benefits from Hamaspik Medicare Select. Benefits and services provided by Hamaspik Medicare Select and contained in my Hamaspik Medicare Select "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Hamaspik Medicare Select 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 authorized representative (as described above), this signature certifies that:*
  1. *This person is authorized under State law to complete this enrollment,*
  2. *Documentation of this authority is available upon request by Medicare.*

Signature:	*Today's Date:*
If you're the authorized representative, sign above and fill out these fields:	
Name:	*Address:*
Phone Number:	*Relationship to Enrollee:*

Hamaspik Medicare SELECT

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, Mexican, Mexican American, Chicano/a*
- ◯ *Yes, Puerto Rican*
- ◯ *Yes, Cuban*
- ◯ *Yes, another Hispanic, Latino/a, or Spanish origin*
- ◯ *I choose not to answer*

What's your race? Select all that apply.

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

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 a language other than English. ◯ *Spanish*

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

◯ *Braille* ◯ *Large Print* ◯ *Audio CD*

Please contact Hamaspik Medicare Choice at 1-888-426-2774 if you need information in an accessible format other than what's listed above. Our office hours are 7 days a week, from 8:00 am to 8:00 pm, October 1, 2024, through March 31, 2025. From April 1, 2025, through September 30, 2025, our Member Service Department will be available Monday through Friday, 8:00 am to 8:00 pm. TTY users should call 711.

Do you work? ◯ *Yes* ◯ *No*

Does your spouse work? ◯ *Yes* ◯ *No*

I want to get the following materials via email. (Select one or more.)

◯ *Evidence of Coverage* ◯ *Provider and Pharmacy Directory* ◯ *Formulary (List of Covered Drugs)*

Email: _____

These documents are also available on our website at www.hamaspik.com.

Paying your plan premiums

There is no plan premium in Hamaspik Medicare Select.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must continue to pay this extra amount. *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 Hamaspik Medicare Select the Part D-IRMAA.*

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 Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42CFR Sections 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 inform is voluntary. However, failure to respond may affect enrollment in the plan.