2023 ENROLLMENT REQUEST FORM
Hartford, Tolland

Want to keep it easy? Enroll by phone at 1-800-964-4525 (TTY 711) or online at trinityhealthofne.org/medicare. If you would rather complete and mail this Enrollment Request Form to us, we have provided instructions below. Follow these easy steps to become a member of Trinity Health Plan Of New England in 2023:

**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 bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

**What happens next?**
Send your completed and signed form to:
ATTN ENROLLMENT
MEDICARE HEALTH PLAN
PO BOX 6111
WESTERVILLE OH 43086-9874

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

**How do I get help with this form?**
Call Trinity Health Plan Of New England at 1-800-964-4525. TTY users can call 1-800-964-4525 (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 Trinity Health Plan Of New England al 1-800-964-4525 (TTY 711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 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.
Select the plan you want to join:
- Trinity Health Plan Of New England No Premium (HMO), $0 monthly premium
- Trinity Health Plan Of New England Cash Back MAPD (HMO), $0 monthly premium ($50 Part B Buy-Back)
- Trinity Health Plan Of New England Cash Back (HMO), $0 monthly premium ($50 Part B Buy-Back)
- Trinity Health Plan Of New England Choice (PPO), $0 monthly premium

<table>
<thead>
<tr>
<th>FIRST name:</th>
<th>LAST name:</th>
<th>Middle Initial:</th>
</tr>
</thead>
</table>

Birth date: (MM/DD/YYYY) | Sex: Male | Female | Phone number: ( ) |
( ___ / ___ / ___ ___ ___ )

Permanent Residence street address (Don’t enter a PO Box):

<table>
<thead>
<tr>
<th>City:</th>
<th>County:</th>
<th>State:</th>
<th>Zip Code:</th>
</tr>
</thead>
</table>

Mailing address, if different from your permanent address (PO Box allowed):

<table>
<thead>
<tr>
<th>Street address:</th>
<th>City:</th>
<th>State:</th>
<th>Zip Code:</th>
</tr>
</thead>
</table>

Your Medicare information:

Medicare Number: __ ___ __ - __ __ - __ __ __

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Trinity Health Plan Of New England? Yes | No

Name of other coverage: ___________________________ Member number for this coverage: ___________________________
Group number for this coverage: ___________________________
IMPORTANT: Read and sign below:

• I must keep both Hospital (Part A) and Medical (Part B) to stay in Trinity Health Plan Of New England.
• By joining this Medicare Advantage, I acknowledge that Trinity Health Plan Of New England 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).
• I understand that when my Trinity Health Plan Of New England coverage begins, I must get all of my medical and prescription drug benefits from Trinity Health Plan Of New England. Benefits and services provided by Trinity Health Plan Of New England and contained in my Trinity Health Plan Of New England “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Trinity Health Plan Of New England 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.
• With Trinity Health Plan Of New England HMO plans, I understand that beginning on the date Trinity Health Plan Of New England coverage begins, I must get all of my medical and prescription drug benefits from Trinity Health Plan Of New England, with the exception of emergency or urgently needed services or out-of-area dialysis services.
• With a Trinity Health Plan Of New England PPO plan, I understand that beginning on the date Trinity Health Plan Of New England coverage begins, out-of-network services will cost more than in-network services with the exception of emergency or urgently needed services or out-of-area dialysis services. When medically necessary, Trinity Health Plan Of New England covers all covered services including those received out-of-network.
• 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.

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Today’s date</th>
</tr>
</thead>
</table>

If you’re the authorized representative, sign above and fill out these fields:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone number:</td>
<td>Relationship to enrollee:</td>
</tr>
</tbody>
</table>
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.

Requested Effective Date:

Optional Medicare Information:
IS ENTITLED TO: HOSPITAL (PART A) EFFECTIVE DATE ________________
MEDICAL (PART B) EFFECTIVE DATE ________________

E-mail Address:

Optional Dental Plans

Please note that the Trinity Health Plan Of New England Cash Back MAPD (HMO) is NOT eligible for the optional dental plans.

If you’re selecting a Trinity Health Plan Of New England HMO plan, you may also choose to enroll in one of our optional dental plans for enhanced comprehensive dental coverage (in addition to the preventive and comprehensive dental benefits already included in HMO plans).

☐ Yes, I would like to enroll in the optional MediGold Dental Silver plan for $21 a month (This is in addition to your Trinity Health Plan Of New England monthly premium.)
☐ Yes, I would like to enroll in the optional MediGold Dental Gold plan for $41 a month (This is in addition to your Trinity Health Plan Of New England monthly premium.)

If you’re selecting a Trinity Health Plan Of New England PPO plan, you may also choose to enroll in one of our optional dental plans for enhanced comprehensive dental coverage (in addition to the preventive and comprehensive dental benefits already included in PPO plans).

☐ Yes, I would like to enroll in the optional MediGold Dental Silver plan for $21 a month (This is in addition to your Trinity Health Plan Of New England monthly premium.)
☐ Yes, I would like to enroll in the optional MediGold Dental Gold plan for $49 a month (This is in addition to your Trinity Health Plan Of New England monthly premium.)

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
☐ Black or African American
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean
☐ Native Hawaiian
☐ Other Asian
☐ Other Pacific Islander
☐ Samoan
☐ Vietnamese
☐ Other Pacific Islander
☐ White
☐ Other

I choose not to answer.

Select one if you want us to send you information in a language other than English.
Indicate your preferred spoken language (if not English)
☐ Spanish
☐ Other __________________________

Indicate your preferred written language (if not English): ☐ Spanish ☐ Other __________________________

If you need information in another language or accessible format (e.g., large print or braille), contact us at 1-800-964-4525 (TTY:711), 8 AM to 8 PM, seven days a week.
Select one if you want us to send you information in an accessible format.

- Braille
- Large print
- Audio CD

Please contact Trinity Health Plan Of New England at 1-800-964-4525 if you need information in an accessible format other than what’s listed above. Our office hours are 7 days a week, 8 a.m. - 8 p.m. TTY users can call 1-800-964-4525 (TTY 711).

Do you work?  Yes  ❌ No  Does your spouse work?  Yes  ❌ No

Optional:
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: ______________________________ Phone Number: ______________________________
Address: __________________________________ Date you entered this facility: ______________________
Are you enrolled in your State Medicaid program?  Yes  ❌ No
If yes, please provide your Medicaid number: __________________________________

Your answer will not keep you from enrolling in this plan.

List your Primary Care Physician (PCP), clinic, or health center:

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**Paying your plan premiums**

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 having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.

MA-PDs with premiums insert: 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. DON’T pay Trinity Health Plan Of New England the Part D-IRMAA.

Please select one premium payment option:

- Get a bill (monthly billing statement)
- Electronic Funds Transfer (EFT) from your bank account each month. If you would like this convenient option, we will mail you a form with instructions on how to complete the process.
- Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (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 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.)

I get monthly benefits from:

- Social Security
- RRB

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**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.
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) ________________.

☐ I was recently released from incarceration I was released on (insert date) ________________.

☐ I recently returned to the United States after living permanently outside the U.S. I returned to the U.S. on (insert date) ________________.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) ________________.

☐ 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) ________________.

☐ 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) ________________.

☐ 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) ________________.

☐ I recently “left” a PACE program on (insert date) ________________.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare’s). I lost my drug coverage on (insert date) ________________.

☐ I am leaving employer or union coverage on (insert date) ________________.

☐ 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) ________________.

☐ 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) ________________.

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

☐ My plan is experiencing financial difficulties to such an extent that a state or territorial regulatory authority has placed the organization in receivership.

☐ My plan has been identified by CMS as a consistent poor performer and is identified with a low performing icon (LPI).

☐ None of these statements apply to me.*

*Please contact Trinity Health Plan Of New England at 1-800-964-4525 (TTY users should call 711) to see if you are eligible to enroll. We are open 7 days a week, 8 a.m. - 8 p.m.