



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](https://www.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 Sections A, B, E, and G. The following are optional: Sections C, D, F, and H — 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:
Experience Health
P.O. Box 25190
Durham, NC 27702

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

How do I get help with this form?

Call Experience Health Medicare Advantage (HMO) at 1-833-905-1298. TTY users can call 711.

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

En español: Llame a Experience Health Medicare Advantage (HMO) al 1-833-905-1298/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:

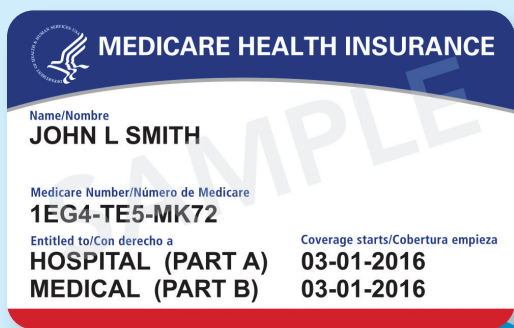
- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., Social Security checks) may be considered your permanent residence address.

2024 Individual Enrollment Form for Experience Health Medicare AdvantageSM (HMO)

A To enroll in Experience Health Medicare Advantage (HMO) \$0.00 per month plan, please provide the following information:

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

Please Note: You must have Medicare Part A and Part B to join a Medicare Advantage Plan.



Your full name *(exactly as it appears on your Medicare Card)*:

Medicare number:

 - -

Hospital (Part A) coverage start date (mm/dd/yyyy):

 / /

Medical (Part B) coverage start date (mm/dd/yyyy):

 / /

Birth Date (mm/dd/yyyy):

 / /

Sex: Male Female

Primary Phone Number:

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Alternate Phone Number: (optional)

 - -

Email Address: (optional)

Permanent Residence Street Address: (P.O. Box is not allowed)

City:

State:

Zip Code:

Mailing Address: (only if different from your permanent residence address; P.O. Box is allowed)

City:

State:

Zip Code:

Emergency Contact: (optional)

Relationship To You:

Phone Number:

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B Please check the county of your permanent residence:

(H3777-001-002)

Durham

Person

(H3777-001-003)

Granville

Orange

Lee

Vance

(H3777-001-004)

Franklin

Wake

C Please tell us the name of your Primary Care Provider (PCP):

Who is your Primary Care Provider:

Practice Name:

Practice Address:

City:

State:

Zip Code:

NPI: (National Provider Identifier#)

I am a: Current Patient New Patient

To find an NPI number, go online to our
Provider Directory at: [ExperienceHealthNC.com](https://www.experiencehealthnc.com)

Please note: If you do not tell us your PCP, we will be in touch to find one for you.

D Paying your plan premium:

Experience Health Medicare Advantage (HMO) is a \$0.00 per month premium plan. However, if Medicare determines you have a Late Enrollment Penalty (LEP), you must pay it to continue your Experience Health Medicare Advantage (HMO) coverage. Please choose how you would like to pay, should you have an LEP:

Please select a payment option:

- Get a bill each month by mail
- Automatic deduction from your monthly Social Security benefit check
- Automatic deduction from your monthly Railroad Retirement Board (RRB) benefit check

Please note: The Social Security/RRB deduction often takes two or more months to begin, even after Social Security or RRB approves the deduction. We will send you a bill for payment by mail until the deduction begins.

You must continue to pay your Medicare Part B premium.

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 Medicare premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). Do not pay Experience Health the Part D-IRMAA.

Financial assistance programs are available for members with limited incomes. Call customer service to learn more about getting assistance.

E Coordination with other health care coverage:

- Yes
 - No
- 1. Will you have other prescription drug coverage, including other private insurance, TRICARE, Federal Employee health benefits coverage, VA benefits or state pharmaceutical assistance programs in addition to Experience Health Medicare Advantage (HMO)? If "yes," please list your other coverage and your identification (ID) number(s) for this coverage.**

ID # for this coverage:

Group # for this coverage:

Name of other coverage:

- Yes
 - No
- 2. Are you enrolled in the North Carolina state Medicaid program? If "yes," please provide your Medicaid number.**

Medicaid number:



If you currently have health coverage from an employer or union, joining Experience Health Medicare Advantage (HMO) could affect your employer or union health benefits. Contact your benefits administrator or the office that answers questions about your coverage to confirm.

F Eligibility for an enrollment period:

Typically, you can sign up for a new Medicare Advantage plan only during the annual enrollment period. 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 enrolling during the **Annual Enrollment Period** (AEP – Oct 15 to Dec 7, 2023). My plan will be effective on January 1, 2024.
- I am enrolling during my **Initial Enrollment Period** (IEP – 3 months before, the month of, and three months after my 65th birthday).
- I am enrolling during the **Open Enrollment Period** (OEP – Jan 1 to March 31, 2024), leaving another MA plan to switch to this one.

If any of the below circumstances apply to you, please check the box(es) that apply and provide relevant date (mm/dd/yyyy).

- I recently moved outside my current plan's service area. Or, I recently moved and this plan is a new option for me. I moved on / / .
Where are you moving from:
 .
(County, State)
- I was recently released from prison on / / .
- I have both Medicare and Medicaid (or North Carolina helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage.
- I recently had a change in the Extra Help I get paying for Medicare prescription drugs (I just got Extra Help, the amount of help I get changed, or I just lost it). This happened on / / .
- I am moving into, live in, or recently moved out of a long-term care facility (like a nursing home). This happened, or will happen on / / .
- I recently left a PACE program on / / .
- I recently lost prescription drug coverage that was as good as Medicare's – and it wasn't my fault. I lost my coverage on / / .

- I am leaving my employer or union coverage on / / .
- I belong to a pharmacy assistance program offered by North Carolina.
- I have been living permanently outside of the United States and recently returned on / / .
- My plan ended its contract with Medicare — or Medicare ended its contract with my plan. My plan is ending on / / .
- My plan is with: .
- I no longer qualify for my Special Needs Plan (SNP). It ends on / / .
- I was eligible for a special enrollment period (I checked at least one of the boxes above) but I missed my change because of a natural disaster, like a

hurricane or a flood. The Federal Emergency Management Agency (FEMA) called it a weather-related emergency or major disaster.

- I recently got lawful presence status in the United States on / / .
- I recently had a change in my Medicaid coverage (for example, I just got Medicaid, the level of assistance I get changed, or I lost Medicaid). This change happened on / / .
- I was enrolled in a plan by Medicare (or North Carolina), but want to choose a different plan. My current plan started on / / .
- None of these statements apply to me.*
Other Special Enrollment Period (SEP) reason:

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*If you need further assistance figuring out if you're eligible to enroll, please contact Experience Health Medicare Advantage (HMO) at: 1-833-905-1311 or, for TTY users, dial 711, 7 days a week, 8 a.m. to 8 p.m. between October 1 – March 31; 8 a.m. to 8 p.m. Monday – Friday between April 1 – September 30.

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 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of the 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.

G**Important: Please read and sign below:**

- I understand that I can be enrolled in only one Medicare Advantage plan at a time – and that enrollment in this plan will automatically end my enrollment in another Medicare Advantage and/or Prescription Drug Plan.
- I must keep both Hospital (Part A) and Medical (Part B) and continue to pay my Medicare Part B premium to stay in the Experience Health Medicare Advantage (HMO) plan.
- By joining this Medicare Advantage plan, I acknowledge that Experience Health Medicare Advantage (HMO) plan will share my information with Medicare and other plans, who may use it to track my enrollment, make payments, and for other purposes allowed by federal law that authorizes the collection of this information (see Privacy Act Statement above).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- 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 when my Experience Health Medicare Advantage (HMO) coverage begins, I must get all of my medical and prescription drug benefits from Experience Health Medicare Advantage (HMO) plan. Benefits and services provided by Experience Health and contained in my Experience Health Medicare Advantage (HMO) 'Evidence of Coverage' document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Experience Health Medicare Advantage (HMO) will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person authorized to act on my behalf under the state laws of North Carolina) on this application means that I have read and understand the contents of this application. If I am signing as an authorized individual, my signature certifies that 1) I am authorized under state law to complete this enrollment form; and 2) documentation of my authority is available upon request from Medicare.

Your Signature:

Today's date (mm/dd/yyyy):

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

First Name:

Last Name:

M.I.

Address:

City:

State:

Zip Code:

Phone Number:

Relationship to Enrollee:

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Email Address: (optional)

H**Optional Information**

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

If you prefer us to send you information in a language other than English, please contact Experience Health Medicare Advantage (HMO), at 1-833-777-7394 (TTY: 711) 7 days a week, 8 a.m. to 8 p.m. Spanish

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

- Braille
 Large Print
 Audio CD

Please contact Experience Health Medicare Advantage (HMO), at 1-833-777-7394 (TTY: 711) 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. to 8 p.m. TTY users can call TTY: 711.

Experience Health is an HMO plan with a Medicare contract. Enrollment in Experience Health Medicare Advantage (HMO) depends on contract renewal. I must keep both Hospital (Part A) and Medical (Part B) to stay in Experience Health Medicare Advantage (HMO). 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. Once I am a member of Experience Health, I have the right to appeal plan decisions about payment or services if I disagree.

Experience Health is an independent licensee of the Blue Cross and Blue Shield Association, serving North Carolina.

[®], SM Marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans

LICENSED AGENT USE ONLY

Agents must submit a completed enrollment form within 24 hours of receipt. Agent certifies that s/he has documentation of the applicant's consent to submit the enrollment form [signed paper application or recorded voice consent (call 833-866-8685)].

Agent's Signature:

Phone Number:

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Print Agent's Name:

NPN #: (required)

Date Application Received (mm/dd/yyyy):

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