ALTERWOOD ADVANTAGE
Quality Care. Better Health.

Enrollment Instructions

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:

Alterwood Advantage
Attn: Sales Department
PO Box 4175
Timonium, MD 21094

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

How do I get help with this form?

Call Alterwood Advantage at 1-866-550-1011. 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 Alterwood Advantage al 1-866-550-1011 (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.

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Section 1 - All Fields on this Page are Required (unless marked optional):

Select the plan you want to join:

- ☐ **Alterwood Advantage Select:** $0 per month
- ☐ **Alterwood Advantage Choice:** $35 per month
- ☐ **Alterwood Advantage Choice Plus:** $125 per month
- ☐ **Alterwood Advantage Freedom:** $0 per month
- ☐ **Alterwood Advantage Dual Secure:** $0 - $39.20 per month (Based on your level of "Extra Help")

FIRST Name:	LAST Name:	Middle Initial:

Birth Date: (MM/DD/YYYY)	Sex:	Home Phone Number (Landline):	Cell Phone Number:
_____/_____/_____	☐ Male ☐ Female	(_____)_____-_____	(_____)_____-_____

Email Address (optional):	Preferred Number:
	☐ Home ☐ Cell

I authorize the health plan to email and text me helpful reminders, articles and tips on healthy living, surveys, and general information about the plan. I understand that I may opt-out of receiving these messages by contacting Member Services at 1-866-675-3944 (TTY: 711), 8 am - 8 pm, ET, 7 days a week from Oct. 1 - Mar. 31 and 8 am - 8 pm, ET, Monday - Friday from Apr. 1 - Sept. 30.

☐ **Yes, I would like to receive messages** ☐ **No, I do not want to receive messages**

Permanent Residence Street Address (Don't enter a PO Box):	Apt. Number:

City:	County:	State:	ZIP code:

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

Street Address:_____Apt. Number:_____

City: _____State:_____ ZIP code:_____

Your Medicare Information:

Medicare Number: ____ ____ ____ ____ - ____ ____ ____ - ____ ____ ____ ____

Answer these Important Questions:

1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Alterwood Advantage? ☐ Yes ☐ No

Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage: _____

2. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If yes, please provide your 11-digit Medicaid number: __ __ __ __ __ __ __ __ __ __ __

3. Are you enrolled in the Maryland Senior Prescription Drug Assistance Program (SPDAP)? ☐ Yes ☐ No

If yes, please provide your SPDAP number: _____

4. Are you a resident of a long-term facility, such as a nursing home? ☐ Yes ☐ No

If "yes," please provide the following information:

Name of Facility: _____ Phone Number of Facility: _____

Address of Facility: _____

Information to Determine Your 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 this information is incorrect, you may be disenrolled.

	I am new to Medicare.
	I am making a change during the Annual Enrollment Period (AEP) from October 15 to December 7.
	I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) from January 1 to March 31.
	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 recently was released from incarceration. I was released on (insert date) _____.
	I recently returned to the United States after living permanently outside of 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.

If none of these statements applies to you or you're not sure, please contact Alterwood Advantage at **1-866-675-3944 (TTY: 711)** to see if you are eligible to enroll. We are open October 1 through March 31, seven days a week from 8 am - 8 pm, and April 1 through September 30, Monday through Friday from 8 am - 8 pm.

Section 2 - All Fields in this Section are Optional

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

1. Are you 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
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ I choose not to answer

2. What's your race? Select all that apply.

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

3. Select one if you want us to send you information in a language other than English.

☐ Spanish ☐ Other _____

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

☐ Braille ☐ Large print ☐ Audio CD

Please contact Alterwood Advantage at 1-866-675-3944 if you need information in an accessible format or language other than what is listed above. Our office hours are 8 am - 8 pm ET, 7 days a week, October 1 - March 31; 8 am - 8 pm ET, Monday - Friday, April 1 - September 30. TTY users should call 711.

5. Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

6. Please choose the name of a Primary Care Physician (PCP). Refer to the plan website or Provider & Pharmacy Directory to choose.

PCP Name _____

PCP Address _____

Are you now seeing or have you recently seen this doctor? ☐ Yes ☐ No

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

- ☐ Evidence of Coverage (EOC)
- ☐ Provider & Pharmacy Directory
- ☐ Drug Formulary

E-mail Address: _____

Paying Your Plan Premium:

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. 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 monthly 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 Alterwood Advantage the Part D-IRMAA.

Please select a premium payment option:

☐ Get a monthly bill

☐ Electronic funds transfer (EFT) from your bank checking account each month.

Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: _____ Bank account number: _____

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

Note: It may take up to 60 days for Social Security or RRB to approve your deduction request. We will mail you a bill until the automatic deductions start.

IMPORTANT - Read and Sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Alterwood Advantage.
- By joining this Medicare Advantage Plan, I acknowledge that Alterwood 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 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 Alterwood Advantage coverage begins, I must get all of my medical and prescription drug benefits from Alterwood Advantage. Benefits and services provided by Alterwood Advantage and contained in my Alterwood Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Alterwood Advantage 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 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.

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.

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

Agent Use Only:	
Agent Name:	
Agent ID:	
Initial Receipt Date:	
Proposed Effective Date of Coverage:	
LIS Level:	Medicaid Level:

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-675-3944. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-675-3944. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-866-675-3944。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-866-675-3944。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-675-3944. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-675-3944. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-866-675-3944 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-675-3944. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-675-3944 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-675-3944. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-675-3944. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-675-3944 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-675-3944. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-675-3944. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-675-3944. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-675-3944. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-866-675-3944 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。