OMB No. 0938-1378
Expires:7/31/2023

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C) OR MEDICARE PRESCRIPTION DRUG PLAN (PART D)

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)

Note: To join My Choice Wisconsin Medicare Dual Advantage (HMO SNP), you must be eligible for Full Medicaid Benefits.

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
- Your Medicaid ID 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:
My Choice Wisconsin Medicare Dual Advantage
Attn: Sales
1617 Sherman Avenue
Madison, WI 53704

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

How do I get help with this form?

Call My Choice Wisconsin Medicare Dual Advantage (HMO SNP) at 1-800-963-0035. TTY users can call Wisconsin Relay System 711.

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

En español: Llame a My Choice Wisconsin Medicare Dual Advantage (HMO SNP) al 1-800-963-0035 (TTY: Wisconsin Relay System 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.

my choice
Medicare
Dual Advantage

OMB No. 0938-1378
Expires:7/31/2023

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

☐ My Choice Wisconsin Medicare Dual Advantage (HMO SNP) – $0 per month

FIRST name:	LAST name:	Middle Initial:

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

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

City:	County:	State:	ZIP Code:

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

Street 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 My Choice Wisconsin Medicare Dual Advantage?

☐ Yes ☐ No

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

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

If yes, please provide your Medicaid number: _____

my choice
Medicare
Dual Advantage

OMB No. 0938-1378
Expires:7/31/2023

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in My Choice Wisconsin Medicare Dual Advantage (HMO D-SNP).
- By joining this Medicare Advantage-Prescription Drug Plan, I acknowledge that My Choice Wisconsin Medicare Dual 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).
- 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 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 My Choice Wisconsin Medicare Dual Advantage coverage begins, I must get all of my medical and prescription drug benefits from My Choice Wisconsin Medicare Dual Advantage. Benefits and services provided by My Choice Wisconsin Medicare Dual Advantage and contained in my My Choice Wisconsin Medicare Dual Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor My Choice Wisconsin Medicare Dual Advantage will pay for benefits or services that are not covered.
- 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.

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

my choice
Medicare
Dual Advantage

OMB No. 0938-1378
Expires:7/31/2023

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.

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

☐ Spanish ☐ Chinese

☐ Hmong ☐ Somali

☐ Russian ☐ Laotian

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

☐ Braille ☐ Large print ☐ Audio CD

Please contact My Choice Wisconsin Medicare Dual Advantage at 1-800-963-0035 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. – 8 p.m. CT, 7 days a week. TTY users can call Wisconsin Relay System 711.

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

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: _____

Address & Phone Number of Institution (number and street):

_____

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

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

☐ Annual Notice of Changes ☐ Formulary (List of Covered Drugs)

☐ Appeals and Grievance Notices ☐ Pharmacy Directory

☐ Enrollment and Disenrollment Notices ☐ Provider Directory

☐ Evidence of Coverage ☐ Summary of Benefits

☐ Part D Notices (including Explanation of Benefits)

E-mail address:

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.