2024 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM

ATRIO HEALTH PLANS

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.

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.

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:

Mail: ATRIO Health Plans Fax: (602) 975-4071
338 Jericho Turnpike #135
Syosset, NY 11791

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

How do I get help with this form?

Call ATRIO Health Plans at 1-877-672-8620 (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 ATRIO Health Plans al 1-877-672- 8620 (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.

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

OMB No. 0938-1378
Expires: 7/31/2024

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 this page to send your completed form to the plan.

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

SELECT THE PLAN YOU WANT TO JOIN:

Medical & Prescription Drug Plan options:

☐ **ATRIO Choice Rx (PPO)**: $0 / mo. (H7006-014-000)

☐ **ATRIO Select Rx (PPO)**: $0 / mo. (H7006-015-000)

Medical ONLY Plan options:

☐ **ATRIO Freedom (PPO)**: $0 / mo. (H7006-017-000)

First Name:_____ **Last Name**:_____ **Middle Initial**: _____ *(Optional)*

Birth Date:_____ **Sex**: ☐ M ☐ F **Home Phone Number**:_____
(MM / DD / YYYY)

Cell Phone Number:_____ **Email:** _____

Please know that by providing your email address, you are agreeing to receive email notifications from us, and by providing your cell phone number, you are agreeing to receive text message notifications from us, as applicable. We will always give you the opportunity to opt-out of future communications.

***Permanent Physical Address*:** (Do NOT enter a PO Box)

Street Address:_____ **Apt. #**: _____

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

Mailing Address: (If different from your permanent residence address (PO Box allowed)):

Street Address: _____**Apt. #**: _____

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

Your Medicare information

Please take out your red, white, and blue Medicare card to complete this section.
Fill out this information as it appears on your Medicare card – OR – attach a copy of your Medicare card from your letter from Social Security or the Railroad Retirement Board

Medicare Number: _____
(Example: 1234-123-1234)

Hospital (Part A) Effective Date:_____

Medical (Part B) Effective Date: _____

You must have Medicare Part A or Part B (or both) to join a Medicare Prescription Drug Plan.

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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, Electronic Funds Transfer (EFT), credit card, over the phone or on our website 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 plan 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 ATRIO Health Plans the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Even if you have Extra Help now you may need to reapply for recertification. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover. If you don't select a payment option, you will receive a bill/invoice each month.

Please select a payment option and follow any further instructions for full set-up:

- ☐ Receive a bill/invoice monthly
- ☐ Automatic Electronic Funds Transfer (EFT) from your bank account – for EFT, visit atriohp.com to sign up on our premium portal
- ☐ Credit Card – for credit card payment, visit atriohp.com to sign up on our premium portal
- ☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get my benefits from: ☐ Social Security ☐ Railroad Retirement Board

(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 due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction or approves deductions to begin after the enrollment effective date, we will send you a bill for your monthly premiums.)

IMPORTANT: Read and Sign Below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in this plan. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it
- By joining this Medicare Advantage Plan, I acknowledge that ATRIO Health Plans 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 or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans)

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- I understand that when my ATRIO coverage begins, I must get all of my medical and prescription drug benefits (If I selected a plan with prescription drug coverage) from ATRIO. Benefits and services provided by ATRIO and contained in my ATRIO "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor ATRIO 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, 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 are the authorized representative, you must sign and fill out these fields below:

Name: _____ **Address**: _____

City:_____ **State:**_____ **Zip Code:**_____

Cell Phone Number:_____ **Relationship to Enrollee**:_____

SECTION 2: A few questions to help us manage your plan *(optional)*

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

2. Select one if you prefer plan information in another language or an accessible format:

☐ Spanish ☐ Large Print ☐ Other:_____

Please contact ATRIO at 1-877-672-8620 (TTY 711) if you need information in an accessible format other than what is listed above. Our office hours are daily, 8:00 a.m. to 8:00 p.m. local time.

3. Do you or your spouse work? ☐ Yes ☐ No

4. Do you have other prescription drug or medical coverage (like group, VA, TRICARE) in addition to this plan? ☐ Yes ☐ No

If yes, please list your other coverage and your ID number for this coverage:

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

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SECTION 2 *continued*: A few questions to help us manage your plan *(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, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Cuban
- ☐ Yes, Puerto Rican
- ☐ **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**

SECTION 3: For licensed sales representative / agency use only

Staff member / Agent / Broker must complete:

Name (if assisted in enrollment):_____**Writing ID#:**_____

Initial receipt date:_____**Proposed effective date of coverage:** _____

- ☐ IEP (MA-PD enrollees)
- ☐ ICEP (MA enrollees)
- ☐ IEP (MA-PD enrollees eligible for 2nd IEP)
- ☐ OEP (Jan 1 – Mar 31)
- ☐ OEP (newly eligible)
- ☐ SEP (Dual LIS change of status)
- ☐ SEP (change in residence)
- ☐ SEP (loss of EGHP coverage)
- ☐ SEP (Chronic)
- ☐ SEP (dual LIS maintaining)
- ☐ SEP (SEP reason):_____
- ☐ AEP (October 15 – December 7)
- ☐ OEPI

_____ _____

Licensed Sales Representative Signature *(optional)* Date

Please mail or fax this completed form to:

ATRIO Health Plans
338 Jericho Turnpike #135
Syosset, NY 11791
Fax: (602) 975-4071

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 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.