CenCal CareConnect™

CenCalHEALTH® Local. Quality. Healthcare.

OMB No. 0938-1378 Expires: 12/31/2026

Individual Enrollment Request Form to Enroll in CenCal CareConnect (HMO D-SNP), a Medicare Medi-Cal Plan

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 Dual Eligible Special Needs Plan, you must also have:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)
- Medi-Cal (The State of California's Medicaid Insurance for low-income individuals)

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

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.

What happens next?

Send your completed and signed form to:

CenCal CareConnect (HMO D-SNP)
4050 Calle Real
Santa Barbara, CA 93110

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

How do I get help with this form?

Call CenCal CareConnect at 1-877-814-1861. 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 CenCal CareConnect al 1-877-814-1861. (TTY: CA Relay al 711) o a Medicare gratis al 1-800-633-4227 y oprima el 8 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.

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.

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.

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.

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

Select the plan you want to join: ☐ CenCal CareConnect (HMO D-SNP) — $0 per month

FIRST name: LAST name: Middle Initial:

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

Phone number: Alternate Phone Number (Optional):

Permanent residence street address (Don't enter a P.O. Box. Note: For individuals experiencing homelessness, a P.O. Box may be considered your permanent residence address.)

City: County: State: Zip:

Mailing address, if different from your permanent address (P.O. Box allowed):

Street address:

City: State: Zip:

Your Medicare information

Medicare Number:

Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to CenCal CareConnect?
☐ Yes ☐ No

Name of other coverage:

Member number for this coverage:

Group number for this coverage:

Dual Special Needs (HMO D-SNP) plans are for those who qualify for Medicare and Medicaid. By enrolling in this plan, you understand that you must remain enrolled in the CenCal Health Medi-Cal plan to remain eligible for CenCal CareConnect.

1) Are you enrolled in your state Medicaid (Medi-Cal) program?
☐ Yes ☐ No

2) If "yes," provide your Medicaid nine-digit number Client Index Number (CIN):

IMPORTANT. Read and sign below

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

Signature:

Date:

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

Name:

Address:

Phone number:

Relationship to enrollee:

Section 2 — All fields in this section 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

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact CenCal CareConnect at **1-877-814-1861** if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m. PT, 7 days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday through Friday (except holidays) from April 1 through September 30.

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

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

I consent to CenCal Health, directly or through third parties acting on its behalf, contacting me about health plan coverage benefits, health care options or services, health education, or any other member-related topic. I understand these messages may be sent to me by text messages, emails, or phone calls to my cell phone, including automated phone calls delivering pre-recorded messages.

☐ Yes ☐ No

You can change your communications preferences at any time by logging in to your online Member Account or calling Member Services.

Email:

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, State Health Insurance Program (SHIP) counselors, family members, or other third parties) helping an enrollee fill out this form.

Name:

Relationship to enrollee:

Signature:

National Producer Number: (Agents/Brokers only)

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.

Attestation of Eligibility for an 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 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 have new options available to 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 Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).
- ☐ 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'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.

Attestation of Eligibility for an Enrollment Period (cont.)

- ☐ 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 an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact CenCal CareConnect at 1-877-814-1861 (TTY users should call 711) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m. PT, 7 days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday through Friday (except holidays) from April 1 through September 30.