To Enroll in Capital Health Plan Retiree Advantage (HMO) in 2025, Please Provide the Following Information:

Capital Health PLAN℠
An Independent Licensee of the Blue Cross and Blue Shield Association

Name of Employer your Retirement Benefits are with:		**Group #:**

State of Florida Members Only: Please choose your plan: ☐ Retiree Advantage ☐ Retiree Classic

State of Florida Retirees please contact Peoples First for notification of plan selection and send copy of Medicare card. Toll-free 1-866-663-4735 Monday through Friday, 8:00 a.m. to 6:00 p.m. EST.

Member Name (Last, First MI:				
Birth Date: / /	**Sex:** ☐ M ☐ F	Home Phone Number: ( )		
Permanent Residence (PO Box is not allowed):		Street:		
City:		State:	ZIP Code:	County:
Mailing Address (If different from your permanent residence):		Street:		
City:		State:	ZIP Code:	County:
Emergency Contact Information		Name:	Home:	Cell:

Please Provide Your Medicare Insurance Information

Medicare Number: ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Please Read And Answer These Important Questions

1. Are you the policyholder? ☐ Yes ☐ No

If Yes, retirement date? (mm/dd/yyyy): _____ Last date covered as active employee: _____

If you **are** the policyholder, are you covering a spouse or dependents under this employer plan?

☐ Yes ☐ No Name of spouse, if applicable: _____

Name of dependents, if applicable: _____

If you are **not** the policyholder, what is the policyholder's name? _____

Policyholder's retirement date (mm/dd/yyyy): _____ Last date covered as active employee: _____

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

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	Member ID # for this Coverage:	Group # for this Coverage:
_____	_____	_____

IMPORTANT: Read and Sign Below:

By completing this enrollment application, I agree to the following:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Capital Health Plan. 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 individual Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15th – December 7th of every year), or under certain special circumstances.
- Capital Health Plan serves a specific service area. If I move out of the area that Capital Health Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Capital Health Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Capital Health Plan when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Capital Health Plan 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 when my Capital Health Plan Retiree Advantage (HMO) coverage begins, I must get all of my medical and prescription drug benefits from Capital Health Plan. Benefits and services provided by Capital Health Plan and contained in my Capital Health Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Capital Health Plan 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) 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 from Medicare.

Signature:	**Today's Date:**

If you are the Authorized Representative, sign above and fill out these fields

Name:	**Address:**
Phone Number:	**Relationship to Enrollee:**

Office Use Only:

Name of Agent/Broker:_____ Agent/Broker Number: _____

Date Application Accepted _____ Effective Date of Coverage: _____

ICEP/IEP:_____ AEP:_____ SEP(type) _____ STAR (R): _____ Not Eligible_____

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

3. List your Primary Care Physician (PCP, clinic, or health care: _____

   Are you an established patient of this primary care physician? ☐ Yes ☐ No

4. 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**.

5. What is 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.**

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

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

   ☐ Evidence of Coverage ☐ Annual Notice of Change

   Email address:_____

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

☐ Braille ☐ Large Print ☐ Audio CD

Please contact our Member Services department at 850-523-7441 or 1-877-247-6512 if you need information in an accessible format other than what's listed above. Our office hours are 8:00 a.m. – 8:00 p.m., seven days a week, October 1 – March 31; 8:00 a.m. – 8:00 p.m., Monday – Friday, April 1 – September 30. State of Florida members call 1-877-392-1532, 7:00 a.m. – 7:00 p.m. TTY users can call 850-383-3534 or 1-877-870-8943.

Please Read And Answer These Important Questions:

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 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 had a change in my Extra Help paying for Medicare prescription drug coverage (newly enrolled in 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.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date). _____
- ☐ 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/my spouse have retired and my active coverage under my employer will end 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 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.
- ☐ I am currently enrolled in a plan that is experiencing financial difficulties to such an extent that a state or territorial regulatory authority has placed the organization in receivership.
- ☐ I am currently enrolled in a plan identified with the low performing icon (LPI)