OMB No. 0938-1378
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2023 Medicare Advantage Plan Individual Enrollment Request Form Cover Page

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:

Cigna
Member Administrative Services
PO Box 20012
Nashville, TN 37202-9919

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

How do I get help with this form?

Call Cigna at **1-800-313-0973 (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 Cigna al **1-800-313-0973 (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.

2023 Medicare Advantage Plan Individual Enrollment Request Form

☐ New Customer ☐ Plan Change ☐ RFI Follow-up

SECTION 1

All fields in this section are required (unless marked optional)

SELECT THE PLAN YOU WANT TO JOIN

Medicare Advantage plan (HMO) with a Part D drug benefit:

☐ Cigna Preferred Medicare (HMO) H4513-061-001 $0 per month

☐ Cigna Alliance Medicare (HMO) H4513-064 $0 per month

☐ Cigna Preferred Savings Medicare (HMO) H4513-066 $0 per month

Medicare Advantage plan (PPO) with a Part D drug benefit:

☐ Cigna True Choice Medicare (PPO) H7849-038 $0 per month
This plan allows you to visit in-network and out-of-network physicians without a referral. See the Summary of Benefits for each plan for more information.

☐ Cigna True Choice Plus Medicare (PPO) H7849-062 $17 per month
This plan allows you to visit in-network and out-of-network physicians without a referral. See the Summary of Benefits for each plan for more information.

Medicare Advantage plan (HMO) with medical benefits only:

☐ Cigna Courage Medicare (HMO) H4513-009 $0 per month

ABOUT YOU

Provide the following information.

Last Name	First Name	Middle Initial

Title	Date of Birth	Gender
☐ Mr. ☐ Mrs. ☐ Ms.	ll / ll / llll	☐ Male ☐ Female

Phone Number	Alternate Phone Number
☐ Home ☐ Cell	☐ Home ☐ Cell

PERMANENT ADDRESS

PO Box is not allowed.

Permanent Residence Street Address

City	State	Zip Code

County

MAILING ADDRESS

Leave blank if same as permanent address.

Street Address

City	State	Zip Code

YOUR MEDICARE INFORMATION

Use your red, white and blue Medicare card to complete this section. Provide this information as it appears on your Medicare card, or attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name	Entitled To	Coverage Starts
	Hospital (Part A)	MM / DD / YYYY
Medicare Number	Medical (Part B)	MM / DD / YYYY

ANSWER THESE IMPORTANT QUESTIONS

Will you have other prescription drug coverage in addition to this plan for which you are applying?
Some people may have other drug coverage, including private insurance, TRICARE, federal employee health benefits coverage, VA benefits or State pharmaceutical assistance programs.

☐ **Yes** ☐ **No**

If Yes, Name of Other Coverage (located on your ID card)

ID Number of Other Coverage	Group Number for Other Coverage
RxBIN	RxPCN
Phone Number	Effective Date || / || / ||||

Do you live in a Long Term Care Facility, such as a nursing home?

☐ **Yes** ☐ **No**

If Yes, Name of Facility

Address

City	State	Zip Code
Phone Number	Date of Admission to Facility || / || / ||||	

Are you enrolled in your State Medicaid program? (Required for Cigna TotalCare and TotalCare Plus)

☐ **Yes** ☐ **No**

If Yes, Medicaid Number	Medicaid Case Number (Texas Only)

STOP
Important: Read and sign below

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

By signing below and providing my phone number, I agree that Cigna, its affiliates, and representatives may contact me regarding additional products or services by calling or texting me at the number listed. I acknowledge these messages may be delivered using an automatic telephone dialing system and/or an artificial or prerecorded voice. I agree that Cigna may use the information provided or obtained in connection with this application, or insurance coverage provided by Cigna including my personal information, to offer me additional products and services or to send related marketing communications regarding Cigna products. I acknowledge that I am not required to provide consent to receive these communications as a condition of applying for coverage. If I choose not to receive marketing communications, I will indicate that below or can withdraw my consent at any time by contacting Cigna.

☐ I do not consent to receive marketing communications at this number..

Signature of Customer/Enrollee or Authorized Representative	**Today's Date**
	|| / || / ||||

AUTHORIZED REPRESENTATIVE

If you are the Authorized Representative (who signed above), you must provide the following information.

Last Name	First Name	Middle Initial

Phone Number	Relationship to Enrollee

Street Address

City	State	Zip Code

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.

ETHNICITY

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**

RACE

What's your race? Select all that apply.

- ☐ American Indian or Alaskan 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**

OTHER LANGUAGE

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

- ☐ Spanish

ACCESSIBLE FORMATS

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

- ☐ Braille
- ☐ Large Print
- ☐ Audio CD

If you need information in a format other than what is listed, please call Cigna at **1-888-284-0268 (TTY 711)**, 8 a.m. to 8 p.m. local time: 7 days a week, October 1 to March 31; and Monday to Friday, April 1 to September 30. Our automated phone system may answer your call during weekends, holidays and after hours.

WORK STATUS

Do you work? ☐ **Yes** ☐ **No**

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

PRIMARY CARE PROVIDER (PCP), CLINIC, OR HEALTH CENTER SELECTION

Refer to the online *Provider Directory* located at **CignaMedicare.com**.

PCP Full Name

Enter PCP ID exactly as it appears in the *Provider Directory*. Include zeros, but not dashes.

Provider/National Provider Number

Are you an existing patient now seeing or have you recently seen this doctor?

☐ **Yes** ☐ **No**

CHRONIC CONDITIONS

This question applies only to those individuals whose plan offers a chronic condition-specific benefit; however, answering this question is not required, and choosing not to respond will not affect your enrollment.

You must be diagnosed with a chronic condition, such as, but not limited to diabetes, heart disease or hypertension to be eligible to receive certain plan benefits. Have you been diagnosed with a chronic condition?

☐ **Yes** ☐ **No**

EMAIL

To receive information via email regarding your plan, helpful tips on healthy living, the "More From Life" newsletter, surveys, marketing communications, and other general information, please provide your email address below. To update your communication preferences, visit myCigna.com.

Email Address

PAYING YOUR PLAN PREMIUMS

If you have a monthly plan premium (or if you currently have a late enrollment penalty), we need to know how you want to pay. You can pay by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) monthly benefit check.

Part D-IRMAA

If you are assessed a Part B or Part D-Income Related Monthly Adjustable Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either 1) have the amount withheld from your Social Security benefit check or 2) be billed directly by Medicare or RRB. DO NOT PAY the Part D-IRMAA to Cigna.

Extra Help

If you have a limited income, you may be able to get *Extra Help* to pay for prescription drugs. If eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles and coinsurance.

Additionally, if you qualify, you will not be subject to the Coverage Gap or a Medicare late enrollment penalty. Many people are able to get these savings and do not know it. For more information about this *Extra Help*:

- Call 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 are able to get *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 your premium, you will be billed for the amount Medicare does not cover.

PLEASE SELECT A PREMIUM PAYMENT OPTION:
If you do not select a payment option, you will receive a bill each month for the amount Medicare does not cover.

☐ **Automatic deduction from your Social Security or Railroad Retirement Board benefit check.**

I get monthly benefits from:

☐ Social Security ☐ RRB

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, we will send you a paper bill for your monthly premiums.

☐ **Get a monthly bill.**

You also have the option of paying your monthly bill online at **CignaMedicare.com/paymybill**.

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.

AGENT USE ONLY

Note: This area must be completed in its entirety to prevent the delay or denial of application.

Proposed Coverage Start Date || ____ / 0 1 / 2 0 2 3 (Must be after the enrollee sign date)	**Select Enrollment Period** ☐ **ICEP** MA or MAPD ☐ **OEP** ☐ **AEP** ☐ **IEP** PDP or MAPD ☐ **SEP** ☐ **OEPI**
SEP Code (Required if SEP selected)	**SEP Date** || / || / ||||
Licensed Sales Agent Name	**Licensed Sales Agent ID**
Licensed Sales Agent Phone Number	**Scope of Appointment ID Number**
Appointment Type	**Date** || / || / ||||

SPECIAL ENROLLMENT PERIOD
Read the following

Usually, you may join a Medicare Advantage plan only during the Annual Enrollment Period from October 15 through December 7 of each year. There are conditions that may allow you to join a Medicare Advantage plan during a Special Enrollment Period outside of the Annual Enrollment Period.

Check the box if the statement applies to you. If you check any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for a Special Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

If the below statements do not apply to you or you're not sure, contact Cigna at **1-800-668-3813 (TTY 711)** to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m. local time, 7 days a week, October to March; and Monday to Friday, April to September. Our automated phone system may answer your call during weekends, holidays, and after hours.

☐ **AEP**	I am enrolling during the Annual Election Period.
☐ **NEW**	I am new to Medicare.
☐ **OEP**	Between 1/1-3/31: I'm in a Medicare Advantage Plan and want to make a change.
☐ **OEP**	Between 4/1-12/31: I'm in a Medicare Advantage Plan and have had Medicare for less than 3 months. I want to make a change.
☐ **MOV**	I moved to a new address that's outside my current plan's service area, or I recently moved and this plan is a new option for me. I moved on: (insert date) __ / __ / ____. I moved to a new address that's still in my plan's service area, but I have new plan options in my new location. I moved on: (insert date) __ / __ / ____.
☐ **LEC**	I left coverage from my employer or union (including COBRA coverage) on: (insert date) __ / __ / ____.
☐ **SNP**	I lost my Special Needs Plan because I no longer have a condition required for that plan on: (insert date) __ / __ / ____.
☐ **LCC**	I lost other, non-Medicare drug coverage that's as good as Medicare drug coverage (creditable coverage), or my other, non-Medicare coverage changed and is no longer considered creditable, on: (insert date) __ / __ / ____.
☐ **PAP**	I'm in a State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.

☐ **RUS**	I moved back to the U.S. after living outside the country on: (insert date) __ / __ / ____.
☐ **PAC**	I dropped my coverage in a PACE (Programs of All-Inclusive Care for the Elderly) plan on: (insert date) __ / __ / ____.
☐ **EOC**	I lost my coverage because my plan no longer covers the area that I live or it ended its contract with Medicare.
☐ **INC**	I was released from jail on: (insert date) __ / __ / ____.
☐ **LAW**	I recently got lawful presence status in the U.S. on: (insert date) __ / __ / ____.
☐ **5ST**	I am enrolling in a 5-star Medicare plan.
☐ **MCD**	I recently had a change in my Medicaid (newly got Medicaid, had a change in my level of Medicaid, or lost Medicaid) on: (insert date) __ / __ / ____.
☐ **NLS**	I recently had a change in my *Extra Help* paying for my drug costs (newly got *Extra Help*, had a change in my level of *Extra Help*, or lost *Extra Help*) on: (insert date) __ / __ / ____.
☐ **DIF**	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) __ / __ / ____.
☐ **DST**	I was affected by an emergency or a major disaster (as declared by the Federal Emergency Management Agency, or by federal, my state, or my local government). One of the other statements on this page applied to me, but I was unable to make my request because of the disaster.
☐ **MDE**	I have both Medicare and Medicaid, my state helps pay for my Medicare premiums, or I get *Extra Help* paying my Medicare drug coverage.
☐ **LT2**	I live in a long-term care facility, like a nursing home or a rehabilitation hospital.

☐ **LTC**	I recently moved out of a long-term care facility, like a nursing home or a rehabilitation hospital on: (insert date) __ __ / __ __ / __ __ __ __.
☐ **ICE**	I already have Hospital (Part A) and recently signed up for Medical (Part B). I want to join a Medicare Advantage Plan.
☐ **RET**	I'm new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started. (insert date) __ __ / __ __ / __ __ __ __.
☐ **MRD**	I had Medicare prior to now, but I'm now turning 65.
☐ **MYT**	I lost my coverage because Medicare ended its contract with my plan. I got a letter from Medicare saying I could join another plan.
☐ **CSN**	I want to join a Special Needs Plan that tailors its benefits to my chronic condition.
☐ **LPI**	I'm in a plan that's had a star rating of less than 3 stars for the last 3 years. I want to join a plan with a star rating of 3 stars or higher.
☐ **REC**	I'm in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan.
☐ **ACC**	I requested Medicare information in an accessible format. I got less time to make my decision, or I didn't get it in time to make a choice before my enrollment period ended.
☐ **IEP**	I had Medicare before, but I'm now turning 65.

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