OMB No. 0938-1378
Expires: 6/30/2026

MEMORIAL HERMANN Health Plan
Medicare *Advantage* Plans

2025 Individual Enrollment Request Form for a Medicare Advantage 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 in the U.S.
- Live in the plans' 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 I. The items in Section II 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:

Memorial Hermann *Advantage*
P.O. Box 19909
Houston, TX 77224-1909

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

How do I get help with this form?
- Call Memorial Hermann *Advantage* at **(855) 645-8448**. 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 Memorial Hermann *Advantage* al (**855) 645-8448/TTY 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.

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Attestation of Eligibility for a Special Enrollment Period

Typically, you may enroll in a Medicare Advantage or Medicare Prescription Drug Plan only during the Annual Enrollment Period (AEP) from October 15 through December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment period.

If you are enrolling outside of the Annual Enrollment Period (AEP), 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.

Proposed Coverage Start Date _____/_____/_____	**SEP Date** _____/_____/_____
☐ AEP	Annual Enrollment Period (October 15 – December 7)
☐ IEP	I am new to Medicare (Initial Enrollment Period).
☐ OEP	I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (January 1 – March 31).
☐ 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 my Medicare after my Part A and/or Part B coverage started (insert date) _____/_____/_____.
☐ MOV	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) _____/_____/_____.
☐ INC	I recently was released from incarceration. I was released on (insert date)____/____/_____.
☐ RUS	I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date)_____/_____/_____.
☐ LAW	I recently obtained lawful presence status in the United States. I got this status on (insert date) _____/_____/_____.
☐ MCD	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)_____/_____/_____.
☐ NLS	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) _____/_____/_____.
☐ MDE	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.

☐ LTC	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 facility on (insert date) _____/_____/_____.
☐ PAC	I recently left a PACE Program on (insert date) _____/_____/_____.
☐ LCC	I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date) _____/_____/_____.
☐ LEC	I am leaving employer or union coverage on (insert date) _____/_____/_____.
☐ PAP	I belong to a pharmacy assistance program provided by my state.
☐ NON	My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
☐ 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) _____/_____/_____.
☐ SNP	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) ____/____/_____.
☐ DST	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 apply to you or you're not sure, please contact Memorial Hermann *Advantage* at (855) 645-8448 to see if you are eligible to enroll. We are open between October 1st and March 31st from 8 a.m. to 8 p.m., 7 days a week (closed on major holidays). We are open between April 1st and September 30th from 8 a.m. to 8 p.m., Monday through Friday (closed on major holidays). TTY users should call 711.

MEMORIAL HERMANN Health Plan
Medicare Advantage Plans

2025 Individual Enrollment Request Form for a Medicare Advantage Plan

Enrollment form is for a: ☐ New MHHP Member ☐ MHHP Member Plan Change

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

Select the plan you want to join

For members who need **both** Medical and Part D Prescription Drug coverage
☐ Memorial Hermann *Advantage* HMO - $0 per month
For members with full dual **Medicare and Medicaid** coverage
☐ Memorial Hermann *Dual Advantage* HMO D-SNP - $0 per month
For members who need Medical coverage **only** – No Part D Prescription Drug coverage
☐ Memorial Hermann Prime Value MA only HMO - $0 per month

Personal and Contact Information

Last Name	First Name	Middle Initial

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

Phone Number (Required)	Alternate Phone Number
☐ Cell ☐ Land Line	☐ Cell ☐ Land Line
( )	( )

Email Address

Permanent Street Address (Don't enter a PO Box) *Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.*	County

City	State	Country (optional)	Zip Code

Mailing Address (if different from Permanent Address)

City	State	Country (optional)	Zip Code

Your Medicare Information

Name (as it appears on your Medicare ID card)	Coverage Start Dates (MM/DD/YYYY)
Medicare ID Number	Hospital (Part A) ____/____/_____ Medical (Part B) ____/____/_____

Answer these important questions

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

Medicaid Number	Medicaid Case Number

Will you have other prescription drug coverage (e.g., VA or TRICARE) in addition to Memorial Hermann *Advantage*? ☐ Yes ☐ No

If yes, Name of other coverage	Effective Date / /	ID Number
Phone Number of other coverage ( )	Rx BIN	Rx PCN

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 ( )	Admission Date / /	

Primary Care Provider (PCP), Clinic, or Health Center Selection (Required)

Full name of Provider	PCP ID or National Provider Number (NPN)
Office location (if multiple offices)	Are you an existing patient? ☐ Yes ☐ No

IMPORTANT – Read and sign below

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

Authorized Representative / Individuals helping enrollee to complete this form
Please complete all information below if you are the authorized representative who signed above or a third party who assisted the enrollee with completing this form.

Name	Phone Number ( )
Address	
City	State / Zip Code
Relationship to Enrollee	

Agent / Broker (*to be completed by Agent assisting in Enrollment*)

Name of Agent	Agent ID	National Producer No.
Phone Number ( )	Date of Appointment / /	Scope of Appointment ☐ Yes ☐ No

Section II – 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. Your answers will be kept private. This information helps to ensure that all customers have equal access to care.

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 Alaska Native
- ☐ Black or African American

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

Native Hawaiian and Pacific Islander

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ 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 if you would like us to send you information in an accessible format.

☐ Large Print

Please contact Memorial Hermann *Advantage* at (855) 645-8448 if you need information in an accessible format other than what's listed above. Our office hours between October 1st and March 31st are 8 a.m. to 8 p.m., 7 days a week. Hours of operation between April 1st and September 30th are 8 a.m. to 8 p.m., Monday through Friday. TTY users can call 711

Work Status

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

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 1860D-1 of the Social Security Act and 42 CFR §§ 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.

Notice of Nondiscrimination

Memorial Hermann Health Plan, Inc., (MHHP), complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MHHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.