MARTIN'S POINT®
MEDICARE ADVANTAGE PLANS

GENERATIONS ADVANTAGE

Individual Enrollment Form

2022 Focus DC (HMO SNP)

A Medicare Advantage Special Needs Plan Focused on Diabetes Care

How to Fill Out this Form
IMPORTANT—Please Read!

This form has seven pages numbered Page 1–Page 7. Page 1 has information about the form and what you'll need to complete it. Pages 2–7 are the Individual Enrollment Application. Each page consists of two sheets—a WHITE ORIGINAL (to be returned to Martin's Point) and a YELLOW COPY (for your records).

1. Use black or blue ink and please write clearly.
2. For each page, write on the white sheet only. The information you write will copy onto the yellow sheet behind it.
3. To begin, open this booklet and slide THIS COVER under the yellow sheet of Page 2. This will prevent your writing on Page 2 from copying onto later pages.
4. Fill out the white sheet of Page 2, pressing down firmly on your pen so the information copies clearly onto the Page 2 yellow sheet.
5. Repeat the process for each of the other pages, making sure to place THIS COVER under each of the yellow sheets as you go.
6. After completely filling out all the pages of the form, tear out and separate the white originals from the yellow copies.
7. Place the white originals in the enclosed envelope and mail to:

   Martin's Point Generations Advantage
   891 Washington Avenue
   PO Box 9746
   Portland, ME 04104
8. Keep the yellow copies for your records.

Be sure to complete the entire enrollment form. Missing or incorrect information will delay enrollment processing.

If you have any questions as you are filling out your enrollment application, please call Martin's Point Generations Advantage at 1-888-408-8285 (TTY: 711).

You can also enroll over the phone at the number above or online at MartinsPoint.org/GetStarted

Individual Enrollment Form

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Please contact Martin's Point Generations Advantage at 1-888-408-8285 (TTY: 711) if you need information in another language or format.

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug 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 can 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 cannot be denied coverage because you do not 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:

Martin's Point Generations Advantage
891 Washington Avenue
PO Box 9746
Portland, ME 04104

Once they process your request to join, they will contact you.

How do I get help with this form?

Call Martin's Point Generations Advantage at 1-888-408-8285 (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 Martin's Point Generations Advantage al 1-888-408-8285 (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.

OMB No. 0938-1378
Expires: 7/31/2023

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Individual Enrollment Form
2022 FOCUS DC (HMO SNP)

Please contact Martin's Point Generations Advantage at 1-888-408-8285 (TTY: 711) if you need information in another language or format.

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

Select the plan you want to join:

☐ Generations Advantage Focus DC (HMO SNP) – $0 per month

IMPORTANT NOTE: The Martin's Point Generations Advantage Focus DC (HMO SNP) plan is available for Cumberland County residents only and includes Part D prescription drug coverage.

FIRST name:	LAST name:	Middle Initial (Optional):
Sex: ☐ Male ☐ Female	Birth (MM/DD/YYYY) __ __/__ __/__ __ __ __	Phone number: ( )

Email (Optional):

Permanent Residence street address (Don't enter a PO Box):

City:	County (optional):	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):

Street address:

City: State: ZIP Code:

Your Medicare information:

Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __

Part A effective date:__ __/__ __/__ __ __ __ Part B effective date:__ __/__ __/__ __ __ __

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Martin's Point Generations Advantage? ☐ Yes ☐ No

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

The Martin's Point Generations Advantage Focus DC (HMO SNP) plan is a Medicare Advantage Special Needs Plan specially designed for people with the chronic condition of diabetes.

If you can answer "Yes" or "Not sure" to any of the questions below, you may be eligible to join our Special Needs Plan. Martin's Point will need to confirm your chronic condition with your doctor within 30 days of enrollment. If we are unable to do so, we are required to disenroll you from the plan.

Has your doctor or other licensed professional diagnosed you with diabetes?

☐ Yes ☐ No ☐ Not sure

Have you had problems with high blood sugar? ☐ Yes ☐ No ☐ Not sure

Do you take medication and/or have you been put on a special diet to control your blood sugar?

☐ Yes ☐ No ☐ Not sure

Health care provider(s) who can confirm your chronic condition:

PROVIDER #1	**PROVIDER #2**
Provider Name:	Provider Name:
Provider Address:	Provider Address:
Provider Phone: ( )	Provider Phone: ( )
Provider Fax: ( )	Provider Fax: ( )

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Martin's Point Generations Advantage.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Martin's Point Generations 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 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 Martin's Point Generations Advantage coverage begins, I must get all of my medical and prescription drug benefits from Martin's Point Generations Advantage. Benefits and services provided by Martin's Point Generations Advantage and contained in my Martin's Point Generations Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Martin's Point Generations Advantage will pay for benefits or services that are not covered.
- AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO VERIFY CHRONIC CONDITION(S): I hereby authorize the disclosure of my health information by the providers listed above to Martin's Point Generations Advantage to verify that I have been diagnosed with a chronic condition which qualifies me to enroll in a Martin's Point Generations Advantage chronic-care Special Needs Plan. This authorization applies to all health information kept by the provider about my medical history for the chronic condition listed above. NOTE: Information disclosed due to this authorization will be protected by Martin's Point Generations Advantage in accordance with applicable state and federal laws and requirements.
- 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:**

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

Name:	Address:
Phone number:	Relationship to enrollee:

Section 2 – All fields on this page are optional

Answering these questions is your choice. You cannot be denied coverage because you do not fill them out.

For communications that can be personalized, what is your preferred method of communication?
☐ Print (letters, brochures, postcards) ☐ Telephonic (home or cell phone)
☐ Digital (email, text messaging, video conferencing

Select one if you want us to send you information in a language other than English.
☐ French ☐ Spanish

Select one if you want us to send you information in an accessible format.
☐ Braille ☐ Large print ☐ Audio CD

Please contact Martin's Point Generations Advantage at 1-888-408-8285 (TTY: 711) if you need information in an accessible format other than what is listed above. We are available 8 am–8 pm, seven days a week from October 1 to March 31; and Monday through Friday the rest of the year.

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

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

Your Primary Care Physician (PCP) must be in the Martin's Point Generations Advantage network. If your current PCP is not in our network, you may choose a new in-network PCP or we will designate an in-network PCP for you. A list of in-network PCPs is available online at MartinsPoint.org/Medicare or by calling Martin's Point Generations Advantage at 1-888-408-8285 (TTY: 711).

Please provide your Generation's Advantage in-network PCP information below:

First Name: Last Name:

Address:

Phone Number (including area code):

Is this your current physician? ☐ Yes ☐ No

☐ Please designate a Primary Care Physician (PCP) for me.

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), or Credit Card 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 must 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). DON'T pay Martin's Point Generations Advantage the Part D-IRMAA.

Please select a premium payment option:
(If you don't select a payment option, you will receive a bill each month by mail.)

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.** I get my monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security or 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.)

☐ **Electronic Funds Transfer (EFT) from your bank account each month.** Please enclose a VOIDED check or provide the following:

Name of Account Holder: _____

Bank Routing Number: _____ Bank Account Number: _____

Account Type: ☐ Checking ☐ Savings

☐ **Credit/Debit Card automatically charged each month.** Please provide the following information:

Card Type: ☐ Visa ☐ MasterCard ☐ Other: _____

Name of Account Holder (as it appears on card): _____

Account Number: _____Exp. Date: ___ ___/___ ___

☐ **Get a bill each month and pay by mail.**

PRIVACY ACT STATEMENT
The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 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.

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment):

_____

_____

Broker received date:

_____

Must be submitted to Martin's Point within 24 hours of this date

Requested effective date of coverage:

_____

☐ ICEP/IEP ☐ AEP ☐ OEP

☐ SEP (type): _____

☐ No in-person meeting conducted, SOA not required

Certify Your 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 this plan is a new option for 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 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 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 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 enrolling in a 5-Star plan during the 5-Star Special Enrollment Period December 8, 2021 through November 30, 2022.

If none of these statements applies to you or you're not sure, please contact Martin's Point Generations Advantage at 1-888-408-8285 (TTY users should call 711 number) to see if you are eligible to enroll. We are available 8 am–8 pm, seven days a week from October 1 to March 31; and Monday through Friday the rest of the year.

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For more information about benefits or enrollment,
or to enroll over the phone, please call
Martin's Point Generations Advantage, toll-free.

1-888-408-8285
(TTY: 711)

We are available 8 am–8 pm, seven days a week from October 1 to March 31; and Monday through Friday the rest of the year.

You can also enroll online at MartinsPoint.org/GetStarted

Martin's Point Generations Advantage is a health plan with a Medicare contract offering HMO, HMO-POS, HMO SNP, Local and Regional PPO products. Enrollment in a Martin's Point Generations Advantage plan depends on contract renewal. You must continue to pay your Medicare Part B premium if not otherwise paid for by Medicaid or another third party.

Please call Martin's Point Generations Advantage at 1-888-408-8285 (TTY: 711) if you need this information in another language or format.

Martin's Point Generations Advantage, 891 Washington Avenue, PO Box 9746, Portland, ME 04104