2025 PLANS

GENERATIONS ADVANTAGE

Individual Enrollment Form

Y0044_2025_134_M Approved: 9/4/2024

Enroll using this form, online, or by phone.

: **MartinsPoint.org/GetStarted** : **1-877-510-1656 (TTY: 711)**

How to fill out this form

Important—please read!

- This form has six pages numbered Page 1—Page 6.
- Use black or blue ink and please write clearly.
- Make a copy of your form for your records.
- Send your completed form to:

  Generations Advantage Enrollment
  Martin's Point Health Care
  PO Box 9746
  Portland, ME 04104
- Confirmation of enrollment letter will be sent to you **within 10 days** to confirm we have received, processed, and completed your enrollment application. **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 1-877-510-1656 (TTY: 711).

Individual Enrollment Form

Please contact Martin's Point Generations Advantage at 1-877-510-1656 (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 Annual Enrollment Period (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:

Generations Advantage Enrollment
Martin's Point Health Care
PO Box 9746
Portland, ME 04104

Confirmation of enrollment letter will be sent to you within 10 days to confirm we have received, processed, and completed your enrollment application.

How do I get help with this form?

Call Martin's Point Generations Advantage at 1-877-510-1656 (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 1-877-510-1656 (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.

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.

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-NEW. 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.

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

Martin's Point

Individual Enrollment Form for All Martin's Point Generations Advantage Plans

2025 **Prime** (HMO-POS), **Value Plus** (HMO-POS), **Alliance** (HMO), **Select** (LPPO), **Access** (LPPO)

Please contact Martin's Point Generations Advantage at 1-877-510-1656 (TTY: 711) if you need information in another language or format.

Section 1 – All fields on pages 1 and 2 are required (unless marked optional)

Select the plan you want to join:

☐ **PRIME (HMO-POS)** *Includes prescription drug coverage*	**Plan Premium**
ME: Cumberland and York Counties	$0 per month
ME and NH: Androscoggin, Kennebec, Sagadahoc, Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan Counties	$29 per month
ME: Aroostook, Franklin, Hancock, Knox, Penobscot, and Washington Counties	$34 per month
ME and NH: Lincoln, Oxford, Piscataquis, Somerset, Waldo, Belknap, Carroll, Coos, and Grafton Counties	$93 per month
☐ **VALUE PLUS (HMO-POS)** *Includes prescription drug coverage*	**Plan Premium**
ME: All Counties	$0 per month
☐ **ALLIANCE (HMO)** *NO prescription drug coverage*	**Plan Premium**
ME and NH: All Counties	$0 per month
☐ **SELECT (LPPO)** *Includes prescription drug coverage*	**Plan Premium**
ME: All Counties	$104 per month
NH: Cheshire, Coos, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan Counties	$104 per month
☐ **ACCESS (LPPO)** *Includes prescription drug coverage*	**Plan Premium**
NH: All Counties	$0 per month

OMB No. 0938-1378
Expires: 7/31/2024

Your personal information:

FIRST name as it appears on your Medicare card:	LAST name as it appears on your Medicare card:
Middle Initial (Optional):	Suffix (Optional):

Sex: ☐ Male ☐ Female

Birth date (MM/DD/YYYY) ___ ___/___ ___/___ ___ ___ ___	Phone number: ( )

Email (Optional):

Permanent Residence Street Address (do not enter a PO Box):

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

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

Street address or PO Box: ____________________

City: ____________________ State: ________ ZIP Code: ____________

Your Medicare information:

Please take out your red, white, and blue Medicare card to complete this section.

- Fill out 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.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Name as it appears on your Medicare Card:

Medicare Number:

Is Entitled To	Effective Date
HOSPITAL (Part A)	____________
MEDICAL (Part B)	____________

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: ______________

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 I can be enrolled in only one Medicare Advantage (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 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.
- 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:

Continue to next page

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.

Are you of 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.**

What's 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.**

Please select your preferred written language:.

☐ English ☐ French ☐ Spanish ☐ Other: ____________________________

Please select your preferred spoken language:

☐ English ☐ French ☐ Spanish ☐ Other: ____________________________

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 1-877-510-1656 (TTY: 711) if you need information in an accessible format other than what is listed above. We are available 8am-8pm, every day from Oct. 1-Mar. 31 and weekdays from Apr. 1-Sep. 30.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

What is your gender? Please select one (optional).

☐ Woman ☐ Man ☐ Non-binary ☐ I use a different term ☐ **I choose not to answer.**

Which of the following best represents how you think of yourself? Please select one (optional).

☐ Lesbian or Gay
☐ Straight, that is, not gay or lesbian
☐ Bisexual
☐ I use a different term
☐ I don't know
☐ **I choose not to answer.**

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

Prime (HMO-POS), Value Plus (HMO-POS), and Alliance (HMO) Plans Only: Your Primary Care Provider (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 1-877-510-1656 (TTY: 711).

Select (LPPO) and Access (LPPO) Plans Only: Plan members are not required to choose a PCP.
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 PCP? ☐ Yes ☐ No

☐ Please designate a Primary Care Provider (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*:

____

National Producer Number (Agents/Brokers only):

____

Requested effective date of coverage:

____

☐ ICEP/IEP ☐ AEP ☐ OEP

☐ SEP (type): ____________________

☐ No in-person meeting conducted, SOA not required

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

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.

Initial Enrollment Period & other new to Medicare situations:

☐ I am new to Medicare.

Medicare Advantage Plan Open Enrollment Period

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

Special Enrollment Periods

☐ 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 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 obtained lawful presence status in the United States. I got this status on *(insert date)* ________________________.

☐ I am leaving employer or union coverage on *(insert date)* ________________________.

☐ I recently left a PACE program 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 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 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 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 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 involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on *(insert date)* ________________________.

☐ 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)* ________________________.

Other:

☐ I was affected by a weather-related emergency or major disaster as declared by either my local, state, or federal government. 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, 2024 through November 30, 2025.

If none of these statements applies to you or you're not sure, please contact Martin's Point Generations Advantage at 1-877-510-1656 (TTY users should call 711 number) to see if you are eligible to enroll. We are available 8am-8pm, every day from Oct. 1-Mar. 31 and weekdays from Apr. 1-Sep. 30.

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

1-877-510-1656 (TTY: 711)

We are available 8am–8pm, every day from Oct. 1–Mar. 31 and weekdays from Apr. 1–Sep. 30.

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, and Local 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 1-877-510-1656 (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