Martin's Point

GENERATIONS ADVANTAGE

2026 PLANS

Change Form

Change plans using this form or online.

: **MartinsPoint.org/ChangeForm**

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 change form, please call Martin's Point Generations Advantage at 1-877-510-1656 (TTY: 711).

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OMB No. 0938-1378
Expires: 6/30/2027

Martin's Point

Change Form for all Martin's Point Generations Advantage plans

2026 **Prime** (HMO-POS), **Essential** (HMO-POS), **Alliance** (HMO), **Select** (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, 2, and 3 are required (unless marked optional)

Name of the plan you are currently enrolled in: _____

Current Monthly Premium

$_____

Requested effective date: *(mm/dd/yyyy; must be in the future)* ___/___/___

Select the plan you want to join:

☐ **PRIME (HMO-POS)** *Includes prescription drug coverage*	**Plan Premium**
ME: Cumberland and York Counties	$38 per month
ME: Androscoggin, Kennebec, and Sagadahoc Counties	$49 per month
ME: Aroostook, Franklin, Hancock, Knox, Penobscot, and Washington Counties	$109 per month
ME: Lincoln, Oxford, Piscataquis, Somerset, and Waldo Counties	$109 per month

☐ **ESSENTIAL (HMO-POS)** *Includes prescription drug coverage*	**Plan Premium**
ME: All Counties	$0 per month
☐ **OPTIONAL SUPPLEMENTAL BENEFIT: DENTAL PLUS** The Martin's Point Generations Advantage Dental Plus option can only be added to the Essential (HMO-POS) plan. The Generations Advantage Dental Plus option premium is $69 per month. The Generations Advantage Dental Plus option is not available for Prime (HMO-POS), Alliance (HMO), or Select (LPPO) plans.	**Dental Plus Premium** $69 per month

☐ **ALLIANCE (HMO)** *NO prescription drug coverage*	**Plan Premium**
ME: All Counties	$0 per month

☐ **SELECT (LPPO)** *Includes prescription drug coverage*	**Plan Premium**
ME: Androscoggin, Cumberland, Kennebec, Sagadahoc, and York Counties	$104 per month
ME: Aroostook, Franklin, Hancock, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Somerset, Waldo, and Washington Counties	$49 per month

☐ I understand that this plan has different health benefits and a different monthly premium. I have reviewed my new plan premium in the chart above.

Your personal information:			
FIRST name as it appears on your Medicare card:	LAST name as it appears on your Medicare card:		
Middle Initial (Optional):	Generations Advantage Member ID number:		
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: _____

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.

Please select your preferred written language:.
☐ English ☐ French ☐ Spanish ☐ Other: _____

Please select your preferred spoken language:
☐ English ☐ French ☐ Spanish ☐ Other: _____

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

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

Prime (HMO-POS), Essential (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 or by calling Martin's Point Generations Advantage at 1-877-510-1656 (TTY: 711).

Select (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: ___ ___/___ ___

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.

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 and Qualifying Events

☐ 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 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 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.

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) 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.