TRIPLE-S ADVANTAGE

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

2021 ELA ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

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
- Comply with your employer eligibility requirements

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 1–December 31 each year (for coverage starting January1)
- 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 1–December 31), the plan must get your completed form by December 31.

- 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:

Triple-S Advantage, Inc.
Enrollment Department
PO Box 11320
San Juan, Puerto Rico 00922-1320

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

How do I get help with this form?
Call Triple-S Advantage at 1-888-620-1919. TTY users can call 1-866-620-2520.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Triple-S Advantage al 1-888-620-1919 / usuarios de TTY 1-866-620-2520 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

TRIPLE-S ADVANTAGE

SECTION 1

ALL FIELDS ON THIS PAGE / SECTION ARE REQUIRED (UNLESS MARKET OPTIONAL):

Scope of Appointment #: _____

SELECT THE PLAN YOU WANT TO JOIN:

___ ELA Royal Plus (HMO-POS)
Monthly Premium $100

___ ELA Titán (HMO-POS)
Monthly Premium $100

___ ELA Óptimo Plus (PPO)
Monthly Premium $100

___ ELA Titán Plus (HMO-POS)
Monthly Premium $100

___ ELA Selecto (HMO-POS)
Monthly Premium $100

Choose as applicable:

____ Sistema de Retiro de Empleados del ELA (530)

____ Sistema de Retiro para Maestros (592)

Member's Classification:

____ Principal (retiree) S.S. num. _____

____ Dependant's S.S. num. _____

BENEFICIARY INFORMATION:

First Name: Last Name: [Optional:Initial]:

Birth Date Month: Day: Year: Sex: F M

Home Phone Number: Alternate Phone Number:

Permanent Residence Street Address (Don't enter a P.O. Box):

City: , PR Zip Code:

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Mailing Address (if different from your Permanent Residence Address. PO Box allowed):

Street Address:

City: , PR Zip Code:

YOUR MEDICARE INFORMATION:

Medicare Number: - -

ANSWER THESE IMPORTANT QUESTIONS:

Will you have other prescription drug coverage (like VA, TRICARE, etc.) in addition to Triple-S Advantage? Yes ☐ No ☐

If "Yes", please list your other coverage and your identification (ID) number(s) for this coverage:

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

IMPORTANT: READ AND SIGN BELOW

By completing this enrollment application, I agree to the following:

1. I must keep both Hospital (Part A) and Medical (Part B) to stay in Triple-S Advantage.
2. By joining this Medicare Advantage Plan, I acknowledge that Triple-S 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).
3. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
4. 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.
5. 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.
6. I understand that when my Triple-S Advantage coverage begins, I must get all of my medical and prescription drug benefits from Triple-S Advantage. Benefits and services provided by Triple-S Advantage and contained in my Triple-S Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Triple-S Advantage will pay for benefits or services that are not covered.
7. 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:
    a. This person is authorized under State law to complete this enrollment, and
    b. Documentation of this authority is available upon request by Medicare.

Signature: _____ **Today's date:** _____

Only for Electronic Enrollment Application completed in person:

Checking "Enroll Now" is considered your signature.
Enroll Now: ____ **Today's date:** _____

Only for Enrollment Application completed by phone:
Call number (UCID): _____ **Today's date:** _____

Witness: _____ **Today's date:** _____

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

Name: _____

Address: _____

Phone Number: _____ Relationship to Enrollee: _____

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.

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

Spanish ____ Other (indicate): _____

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

Braille ____ Large Print ____ Audio CD _____

Please contact Triple-S Advantage at 1-888-620-1919 if you need information in an accessible format or language other than what's listed above. Our office hours are Monday through Sunday from 8:00 a.m. to 8:00 p.m. TTY users can call 1-866-620-2520.

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

For HMO Plans - Please, choose the name of a Primary Care Physicians (PCP), clinic or health center from our Providers Directory: _____
Phone Number: _____
If you do not choose a PCP, one will be assigned to you automatically.

I want to get the following materials via email, (select one or more):

___ Provider Directory
___ Annual Notice of Changes
___ Evidence of Coverage
___ Summary of Benefits
___ Prescription Drug Formulary
___ Promotional materials to maintain your health, appointment reminders, and any other health communication of the Plan.

E-mail Address: _____

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If you do not wish to receive communications via email or text messages, you can communicate anytime to our Members Service Center at 1-888-620-1919, Monday through Sunday from 8:00 a.m. to 8:00 p.m. TTY (Hearing Impaired) should call 1- 866-620-2520.

_____Agree to receive information by: _____ Email ____ Text Messages

_____Do not Agree to receive information by: _____ Email ____ Text Messages

Emergency Contact: _____ Phone Number: _____

Relationship to you: _____

Are you the retiree? Yes ___ No ___ **(Only for employer groups)**

If "Yes", retirement date (month/date/year): _____

If no, name of retiree: _____

Are you covering a spouse or dependents under this employer or union plan? **(Only for employer groups)**

___Yes ___ No ___ Not applicable

If "Yes", name of spouse: _____

Name(s) of dependent(s): _____

Are you a resident in a long-term care facility, such as a nursing / elderly home? Yes ___ No ____

If "Yes," please provide the following information:

Name of Institution: _____

Administrator's name: _____

Institution or administrator's phone number: _____

Current Health Plan: __ MMM __ Humana __ MCS __ Medicare Original __ Other:_____

PAYING YOUR PLAN PREMIUM:

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 automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, 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 have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Triple-S Advantage Inc. the Part D-IRMAA.

PLEASE SELECT A PREMIUM AND/OR LATE ENROLLMENT PENALTY PAYMENT OPTION:

If you don't select a payment option, you will get a coupon book.

_____ Get a coupon book

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

Account holder's name: _____
Bank routing number: _ _ _ _ _ _ _ _ _
Bank account number: _ _ _ _ _ _ _ _ _ _ _ _
Account type: _____ Checking _____Savings

_____ Credit Card. Please provide the following information:

Type of card: __ *Visa* __ *Master Card*
Name of account holder as it appears on card: _____
Card number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Expiration date: _ _/_ _ _ _ (MM/YYYY)

_____ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) 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.)

IMPORTANT INFORMATION ABOUT SPECIAL SUPPLEMENTAL BENEFITS FOR THE CHRONICALLY ILL:

Some of our plans offer Special Supplemental Benefits for the Chronically Ill (SSBCI), this means that to be eligible to receive these benefits, the member must comply with all the following:

- Have one or more comorbid and medically complex chronic conditions that are life-threatening or significantly limit the member's overall health or function;
- Have a high risk of hospitalization or other adverse health outcomes; and
- Require intensive care coordination.

If you chose ELA Titán or ELA Selecto, please answer the following:

Do you comply with all the requirements to receive the Special Supplemental Benefits for the Chronically Ill (SSBCI) as described before? ___ Yes ___ No

If the answer is "Yes", I understand that to receive the Special Supplemental Benefits for the Chronically Ill (SSBCI) I must comply with all requirements stated before and that Triple-S will perform a clinical verification in order to be eligible to receive these benefits. If after clinical validation I do not comply with requirements, I will be eligible to receive all other benefits in my plan package for the exception of the Special Supplemental Benefits for the Chronically Ill (SSBCI).

I CERTIFY TO HAVE RECEIVED THE FOLLOWING DOCUMENTS FROM THE TRIPLE-S ADVANTAGE REPRESENTATIVE:

____ Initial Package (Summary of Benefits, Pre-Enrollment Checklist)
____ Medicare Star Rating Notice
____ Notice of web availability of Evidence of Coverage, Drug Formulary and Provider and Pharmacy Directory
____ Attestation of Eligibility for an Enrollment Period (if applicable)
____ Enrollment Form Copy (if applicable)
____ Electronic Enrollment Confirmation (if applicable)
____ Authorization to Disclose Protected Health Information (PHI form) (if applicable)

The following only apply if the Notice of web availability of Evidence of Coverage, Drug Formulary and Provider and Pharmacy Directory was not provided:

____ Evidence of Coverage and Durable Medical Equipment Formulary (if applicable)
____ Provider and Pharmacy Directory (if applicable)
____ Drug Formulary (if applicable)

OFFICIAL USE ONLY:

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

NPN: _____

Plan ID #: _____ Effective Date of Coverage: _____

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.