TRIPLE-S ADVANTAGE

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

2021 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

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 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 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:

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.

SECTION 1

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

Scope of Appointment #: _____

Select the plan you want to join:

☐ Basic (HMO)
Monthly Premium $0

☐ Real (HMO)
Monthly Premium $0

☐ Enlace (HMO)
Monthly Premium $0

☐ Magno (HMO-POS)
Monthly Premium $0

☐ Brillante (HMO-POS)
Monthly Premium $0

☐ Óptimo (PPO)
Monthly Premium $0

☐ Óptimo Plus (PPO)
Monthly Premium $99

☐ Platino Plus (HMO-SNP)
Monthly Premium $0

☐ Platino Ultra (HMO-SNP)
Monthly Premium $0

☐ Platino Blindao (HMO-SNP)
Monthly Premium $0

☐ Platino Advance (HMO-SNP)
Monthly Premium $0

☐ Platino Enlace (HMO-SNP)
Monthly Premium $0

☐ Platino Alcance (HMO-SNP)
Monthly Premium $0

☐ Contigo Plus (HMO-SNP)
Monthly Premium $0

PLEASE INDICATE IN WHICH GROUP PLAN YOU WANT TO ENROLL IN (IF APPLICABLE):

Coverage: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Choose: ☐ (HMO) ☐ (PPO)

Monthly Premium: ☐☐☐☐☐☐☐☐☐☐☐☐

Effective Date: Mes: ☐☐ Día: ☐☐ Año: ☐☐☐☐

SS Number (Only for group plans.): ☐☐☐ ☐☐ ☐☐☐☐

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BENEFICIARY INFORMATION:

First Name: Last Name: Middle Initial:

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

Home Phone Number: Alternate Phone Number:

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

City: , PR Zip code:

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:

If you choose any of our Platino plans, please answer the following:

Are you enrolled in your State's Medicaid Program? Yes ☐ No ☐

If "Yes", please provide your Medicaid number (MPI): _____

If you choose to enroll in *Contigo Plus* (HMO-SNP), please select the chronic condition that you have been diagnosed with:

☐ Diabetes Mellitus ☐ Cardiovascular Disorder ☐ Chronic Heart Failure

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. For **Óptimo (PPO)** and **Basic (HMO)**: I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.
4. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
5. 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.
6. 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.
7. 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.
8. 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 Physician (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: _____

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 ***Contigo Plus, Real, Platino Plus, Platino Ultra, Platino Alcance, Basic or Óptimo***, 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).

IMPORTANT INFORMATION ABOUT THE EXTENDED CARE PACKAGE "LA ÑAPA":

Some of our plans include an extended care package. If you choose to enroll in ***Contigo Plus, Enlace*** or ***Platino Enlace***, you must select one of the benefits below at no extra cost ($0). The benefit you select will be effective from the first day your enrollment takes effect, while you are a member of ***Contigo Plus, Enlace*** or ***Platino Enlace*** or until December 31, 2021. Your benefit selection on this enrollment form is final and you may not change it during the year. Chosen benefit follows the same restrictions as the standard supplemental benefit.

If you enroll in *Contigo Plus*, select one (1) of these five (5) benefits:

☐ Eyewear - Up to $150 per year as an added allowance value to the standard supplemental eyewear benefit.

☐ Transportation - Up to sixteen (16) trips per year as an added benefit to the standard supplemental benefit.

☐ Dental - Up to $1,000 per year as an added allowance value to the standard supplemental comprehensive dental benefit.

☐ Hearing Aid - Up to $1,500 per year as an added allowance value to the standard supplemental hearing aid benefit.

☐ Over-the-Counter (OTC) - Up to $30 every three (3) months as an added allowance value to the standard supplemental OTC benefit.

If you enroll in *Enlace*, select one (1) of these five (5) benefits:

☐ Eyewear - Up to $150 per year as an added allowance value to the standard supplemental eyewear benefit.

☐ Transportation - Up to twenty-four (24) trips per year as an added benefit to the standard supplemental benefit.

☐ Dental - Up to $1,000 per year as an added allowance value to the standard supplemental comprehensive dental benefit.

☐ Hearing Aid - Up to $1,500 per year as an added allowance value to the standard supplemental hearing aid benefit.

☐ Over-the-Counter (OTC) - Up to $25 every three (3) months as an added allowance value to the standard supplemental OTC benefit.

If you enroll in *Platino Enlace*, select one (1) of these five (5) benefits:

☐ Eyewear - Up to $150 per year as an added allowance value to the standard supplemental eyewear benefit.

☐ Transportation - Up to eighteen (18) trips per year as an added benefit to the standard supplemental benefit.

☐ Dental - Up to $1,500 per year as an added allowance value to the standard supplemental comprehensive dental benefit.

☐ Hearing Aid - Up to $1,500 per year as an added allowance value to the standard supplemental hearing aid benefit.

☐ Over-the-Counter (OTC) - Up to $25 every three (3) months as an added allowance value to the standard supplemental OTC benefit.

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)
☐ Precertification of Chronic Diseases (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.

Triple-S Advantage, Inc. is an independent licensee of BlueCross BlueShield Association. Platino plans are available to anyone who has both Medical Assistance from the State and Medicare.
Triple-S Advantage, Inc. cumple con las leyes federales aplicables de derechos civiles y no discrimina por razón de raza, color, origen de nacionalidad, edad, discapacidad, o sexo. Triple-S Advantage, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Triple-S Advantage Inc. 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人 ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call: 1-888-620-1919 (TTY: 1-866-620-2520). ATENCIÓN: Si usted habla español, servicios de asistencia lingüística están disponibles libre de cargo para usted. Llame al: 1-888-620-1919 (TTY: 1-866-620-2520). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-620-1919 (TTY: 1-866-620-2520）. Y0082_107021E053_C