TRIPLE-S ADVANTAGE

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

2023 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:

Plans without Prescription Drug Coverage (Part D)

___ Basic (HMO)
Monthly Premium $0

___ Óptimo (PPO)
Monthly Premium $0

PPO plans with Prescription Drug Coverage (Part D)

___ Óptimo Plus (PPO)
Monthly Premium $0

___ Óptimo Xtra (PPO)
Monthly Premium $40

HMO and HMO-POS with Prescription Drug Coverage (Part D)

___ Real (HMO)
Monthly Premium $0

___ Magno (HMO-POS)
Monthly Premium $0

___ Brillante (HMO-POS)
Monthly Premium $0

___ AhorroMax (HMO)
Monthly Premium $0

___ Enlace Plus (HMO)
Monthly Premium $0

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

Platino Plans (for individuals with dual Medicare and Medicaid eligibility)

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

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

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

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

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

___ Platino Titán (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: _____

SS Number (Only for group plans.): _____

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BENEFICIARY INFORMATION:

First Name: _____ Last Names: _____ [Optional: Middle Initial]: _____

Birth Date (MM/DD/YYYY): _____ Sex: ___ F ___ M

Home
Phone Number: _____

Alternate
Phone Number: _____

Permanent Residence 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

Are you Hispanic, Latino/a, or of Spanish origin? Select all that apply:

____No, I am not of Hispanic, Latino/a, or Spanish origin

____Yes, Mexican, Mexican American, Chicano/a

____Yes, Puerto Rican

____Yes, Cuban

____Yes, other 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**

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.

Do you agree to be contacted by automated calls and/or text messages to your phone number?
Yes ____ No ____

By choosing yes, you agree that we may establish communication through automated calling and/or text messaging, including to phones registered on any state or federal (Do Not Call List).

In addition, do you authorize us to use contact information such as email addresses, telephone numbers, and mailing addresses provided by means authorized by law?
Yes ____ No ____

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: _____

For opting out of receiving communications via email or text messages, you can communicate anytime with our Member Services 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. Please note that if you opt out of receiving communications via text or email you will still be receiving transactional communications such as Service Coverage Determinations among others.

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 elected coverage that includes Special Supplemental Benefits for the Chronically Ill (SSBCI), please note that in order to receive these benefits you must meet all of the requirements set forth above, and that Triple-S will perform a clinical verification in order to validate your eligibility. If after the clinical validation you do not meet the requirements, you will be eligible to receive all other benefits in your plan package except for 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)
____ 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 applies 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: _____

Receipt Date: _____

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 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.