TRIPLE-S ADVANTAGE

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

2024 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.

Individuals experiencing homelessness

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 as your permanent residence address.

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 OMB0938-1378)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.

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 0938-1378. The time required to complete this information is estimated to average20 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 the accuracy of the time estimate(s) or suggestions for improving this form, please write: CMS,7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 $30

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 Enlace (HMO-SNP)
Monthly Premium $0

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

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

☐ Platino Selecto (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.): _____

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). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
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. I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
5. 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.
6. The information on this enrollment form is correct to the best of my knowledge. In understand if I intentionally provide false information on this form, I will be disenrolled from the plan.
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

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:

- ____Asian Indian
- ____Chinese
- ____Filipino
- ____Japanese
- ____Korean
- ____Vietnamese
- ____Other Asian

____Black or African American

Native Hawaiian and Pacific Islander:

- ____Guamanian or Chamorro
- ____Native Hawaiian
- ____Samoan
- ____Other Pacific Islander

____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 via text message using the contact information provided by you or by means authorized by law?

Yes____ No____

Do you agree to be contacted via e-mail?

Yes____ No____

E-mail Address:_____

I want to get the following materials and information via e-mail, (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.
___ Electronic Enrollment Confirmation (for telephonic enrollments only)

For opting out of receiving communications via e-mail, calls 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 e-mail, calls or text messages 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 __ USA Plan __ 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 have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T 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 Ratings Notice**
____ **Notice of web availability of Evidence of Coverage, Drug Formulary and Provider and Pharmacy Directory**
____ **Enrollment Confirmation (if applicable)**
____ **Enrollment Form Copy (if applicable)**
____ Attestation of Eligibility for an Enrollment Period (if applicable)
____ Precertification of Chronic Diseases (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.

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).