ELEVATE
MEDICARE ADVANTAGE
Denver Health Medical Plan Inc.
OMB No. 09381378 Expires:7/31/2024

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 (forcoverage starting January1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed tojoin or switch plans

Visit Medicare.gov to learn more about when youcan sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on yourred, 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:
Elevate Medicare Advantage
777 Bannock St., MC 6000
Denver, CO 80204

Once they process your request to join, they will contact you.

How do I get help with this form?

Call Elevate Medicare Advantage (303) 602-2451. TTY users can call 711.

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

En español: Llame a Elevate Medicare Advantage al (303) 602-2451/TTY 711 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible paraasistirle.

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 your permanent residence address.

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 average 20 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 you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. 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 OMB 0938-1378) 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.

Individual Enrollment Request Form

Please contact Elevate Medicare Advantage if you need information in another language or format (Braille). To Enroll in Elevate Medicare Advantage, Please Provide the Following Information:

Section 1: – All fields on this page are required (unless marked optional)

Select the plan you want to join:

☐ Elevate Medicare Choice (HMO D-SNP) - $41.60 per month
☐ Elevate Medicare Select (HMO) - $0 per month

LAST Name:____________________FIRST Name:______________________(Optional)MIDDLE Initial: _______

	Mr. ☐	Mrs. ☐	Ms. ☐

Birth date: (MM/DD/YYYY) (_____________________)	Sex:	Home Phone Number:	Alternate Phone
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	County:	State:	Zip Code:
Mailing Address (only if different from your Permanent Residence Address):			
City:	County:	State:	Zip Code:

Emergency contact:	Relationship to You:
Phone Number:	E-mail address:

Please provide your Medicare Insurance Information:

Please take out your red, white and blue Medicare Card to complete this section.

- Fill out this information as it appears on your Medicare card

OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board on your Medicare card

Name (as it appears on your Medicare Card):

____

Medicare Number:_____________________________

Is Entitled to: ______________________________

Effective Date:

HOSPITAL (Part A) ______________________

MEDICAL (Part B) ______________________

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

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Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

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

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Chinese
- ☐ Japanese
- ☐ Other Asian
- ☐ Vietnamese
- ☐ **I choose not to answer.**
- ☐ Asian Indian
- ☐ Filipino
- ☐ Korean
- ☐ Other Pacific Islander
- ☐ White
- ☐ Black or African American
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

- ☐ Spanish
- ☐ Braille, CD, or large print

Please contact Elevate Medicare Advantage at 303-602-2111 or toll free 1-877-956-2111 if you need information in an accessible format/language other than what is listed above. Our office hours are 8 a.m. - 8 p.m. seven days a week. TTY users should call 711.

Section 3 – Paying Your Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, credit or debit 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 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 RRB. DO NOT pay Elevate Medicare Advantage the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty.

Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. If you don't select a payment option, you will get billed each month using our monthly invoice option.

Please select a premium payment option:

☐ Receive a monthly invoice that you will submit along with a check or money order made out to Denver Health Medical Plan, Inc. for your monthly premium. Please note: we cannot accept cash payments. Premium payments are due by the last day of each month to:
Elevate Medicare Advantage
PO Box 5363
Denver, CO 80217-9909

☐ You can have the plan premium charged monthly to a credit or debit card. Contact Member Services at 303-602-2111 for more information on how to pay your plan premium this way. TTY users should call 711. Our hours of operation are 8 a.m. - 8 p.m. seven days a week.

☐ 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.)

Section 4 Please Read and Answer These Important Questions:

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Elevate Medicare Advantage?

Yes ☐ No ☐

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

Name of other coverage: ____________________ ID # for this coverage: ____________________ Group # for this coverage: ______________________

Are you a resident in a long-term care facility, such as a nursing home?

Yes ☐ No ☐

If "yes," please provide the following information:

Name of Institution: ________________________________ Address:______________________________

Phone Number:____

Are you enrolled in your State Medicaid program?
Yes ☐ No ☐

If "yes", please provide your Medicaid number: ________________________________

Do you or your spouse work? Enrollee: Yes ☐ No ☐

Spouse: Yes ☐ No ☐

Are you eligible for Medicare and Full Medicaid Benefits? Yes ☐ No☐

If "yes", please provide your Medicaid number:________________________________ or attach a copy of your Medicaid card or letter.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Elevate Medicare Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Elevate Medicare Advantage. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below

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

Elevate Medicare Advantage is a Medicare Advantage plan and has a contract with the Federal government. I must keep both Hospital (Part A) and Medical (Part B) to stay enrolled in Elevate Medicare Advantage. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan.

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).

By joining this Medicare Advantage, I acknowledge that Elevate Medicare 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.

I understand that when Elevate Medicare Advantage coverage begins, I must get all of my medical and prescription drug benefits from Elevate Medicare Advantage. Benefits and services provided by Elevate Medicare Advantage and contained in my Elevate Medicare Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Elevate Medicare Advantage will pay for benefits or services that are not covered.

It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. 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. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

Elevate Medicare Advantage serves a specific service area. If I move out of the area that Elevate Medicare Advantage serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Elevate Medicare Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Elevate Medicare Advantage when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. Border.

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 if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Denver Health Medical Plan, Inc., he/she may be paid based on my enrollment in Elevate Medicare Advantage.

Release of Information:

By joining this Medicare health plan, I acknowledge that Elevate Medicare Advantage will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Elevate Medicare Advantage will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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 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:

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.

If you are the authorized representative, you must sign above and provide the following information: Name: ____ Address: ____ Phone Number: _________________________ Relationship to Enrollee: ______________________	
Home Office Use Agent Name: _____________________ Agent Signature: __________________	Today's Date: ___________________ Agent NPN: ____________________

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