

---

## BRAVEN HEALTH<sup>SM</sup>

### MEDICARE ADVANTAGE PLAN ENROLLMENT FORM

---

#### 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](https://www.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:

Braven Health  
PO Box 10138  
Newark, NJ 07101-9633

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

#### How do I get help with this form?

Call Braven Health at 1-833-713-1313. 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 Braven Health al 1-833-713-1313 (TTY 711) 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 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.



## Section 2- All fields on this page are optional

Please tell us a little more about yourself. **Answering these questions is your choice. You can't be denied coverage because you don't fill them out.**

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

Spanish

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

Large print

Please contact Braven Health at 1-800-272-8360 if you need information in an accessible format other than what's listed above (i.e. Braille or Audio CD). Our office hours are Monday-Friday, 8 am-8 pm. TTY users can call 711.

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

List your Primary Care Physician (PCP), clinic, or health center from our Provider Directory at BravenHealth.com.:

Please list the Location Code for your PCP. The Location Code begins with a letter and is followed by four numbers. To find the Location Code, search for your PCP on our website at BravenHealth.com (click "Find a Doctor"), then click on your PCP's name. The Location Code appears in the "Location Information" section of the PCP's profile. You can also find the Location Code in the printable Provider Directory located on our website. \_\_\_\_\_

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

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

E-mail address: \_\_\_\_\_

By providing your email address, you agree to receive select educational and marketing communications from Braven Health via email.

### Paying your plan premiums

If your plan has a premium, you can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, phone or on the online Member Portal 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 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.** The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). **DON'T** pay Braven Health the Part D-IRMAA.



## Attestation of Eligibility for an Enrollment Period

**Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year.** There are exceptions that may allow you to enroll in a Medicare Advantage plan outside this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- |   |   |
|---|---|
| <input type="checkbox"/> I am new to Medicare.  | <input type="checkbox"/> I recently left a PACE program on (insert date) _____.   |
| <input type="checkbox"/> I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).  | <input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.   |
| <input type="checkbox"/> I recently moved outside of the service area for my current plan, or I recently moved and this plan is a new option for me. I moved on (insert date) _____.  | <input type="checkbox"/> I am leaving employer or union coverage on (insert date) _____.  |
| <input type="checkbox"/> I recently was released from incarceration. I was released on (insert date) _____.   | <input type="checkbox"/> I belong to a pharmacy assistance program provided by my state. (check one)<br><input type="checkbox"/> Pharmaceutical Assistance to the Aged and Disabled (PAAD)<br><input type="checkbox"/> Senior Gold (SG)   |
| <input type="checkbox"/> I recently returned to the United States after living permanently outside the U.S. I returned to the U.S. on (insert date) _____.  | <input type="checkbox"/> My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.   |
| <input type="checkbox"/> I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.   | <input type="checkbox"/> I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.   |
| <input type="checkbox"/> I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.  | <input type="checkbox"/> I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualifications required to be in that plan. I was disenrolled from the SNP on (insert date) _____.  |
| <input type="checkbox"/> I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.        | <input type="checkbox"/> I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster. |
| <input type="checkbox"/> I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.                      | <input type="checkbox"/> I have had Medicare prior to now, but am now turning 65.   |
| <input type="checkbox"/> I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____. | <input type="checkbox"/> None of these statements apply to me.†   |

†If none of these statements applies to you or you're not sure, please contact Braven Health at 1-833-713-1313 to see if you are eligible to enroll. We are open Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. TTY users should call 711.

---

Braven Health has a Medicare contract to offer PPO Medicare Advantage and Medicare Advantage with Prescription Drug plans. Enrollment in Braven Health's products depends on contract renewal. Products are provided by Braven Health, an independent licensee of the Blue Cross Blue Shield Association. The Blue Cross® and Blue Shield® names and symbols are registered marks of the Blue Cross Blue Shield Association. The Braven Health<sup>SM</sup> name and symbols are service marks of Braven Health. ©2023 Braven Health. Three Penn Plaza East, Newark, New Jersey 07105.