# BRAVEN HEALTH<sup>SM</sup> MEDICARE ADVANTAGE PLAN ENROLLMENT FORM

#### Who can use this form?

Braven

People with Medicare who want to join a Medicare Advantage Plan

HEALTH

#### 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: 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.

S	Section 1- All fields o	on this page are req	luired	
Select the plan you want to join (only one):         □ Braven Medicare Choice (PPO) - \$0 per month (all New Jersey counties)         □ Braven Medicare Freedom (PPO) - \$35 per month (Bergen, Essex, Hudson, Middlesex, Monmouth, Ocean, Passaic and Union counties)				
FIRST name:		LAST name:		
Birth date: (MM/DD/YYYY) (//)		Sex: $\Box$ Male $\Box$ Female	Phone number:	
Permanent Residence street address (Don't enter a PO		) Box):	Apartment/Unit No.:	
City:	County:	State:	ZIP Code:	
Mailing address, if different from your permanent address (PO Box allowed):         Street Address:         Apartment/Unit No.:         City:       Image: Content of the state in the sta				
	Your Medic	are information:		
Medicare Number:				
	Answer these in	mportant questions:		
Will you have other prescription drug coverage (like VA, TRICARE) in addition to Braven Health? $\Box$ Yes $\Box$ NoName of other coverage:Member number for this coverage:Group number for this coverage:				
	IMPORTANT: ]	Read and sign below:		
<ul> <li>I must keep both Hospital (Part A) and Medical (Part B) to stay in Braven Health.</li> <li>By joining this Medicare Advantage Plan, I acknowledge that Braven Health 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).</li> <li>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).</li> <li>Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.</li> <li>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.</li> <li>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.</li> <li>I understand that when my Braven Health coverage begins, I must get all of my medical and prescription drug benefits from Braven Health. Benefits and services provided by Braven Health and contained in my Braven Health "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Braven Health will pay for benefits or services that are not covered.</li> <li>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: <ul> <li>1) This person is authorized under State law to complete this enrollment, and</li> <li>2) Documentation of this authority is available upon request by Medicare.</li> </ul> </li> </ul>				
Signature:		Today's date:		
If you're the authorized rep	resentative, sign above and	1		
Name:		Address:		
Phone number:		Relationship to enrollee		

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 info	ormation 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? $\Box$ Yes $\Box$ NoDoes your spouse work? $\Box$ Yes $\Box$ 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.				
$\Box$ No, not of Hispanic, Latino/a, or Spanish o	rigin 🗆 Yes, Mexi	can, Mexican American, Chicano/a		
□ Yes, Puerto Rican				
□ Yes, another Hispanic, Latino/a, or Spanish				
□ I choose not to answer.	C			
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:				
<b>Paying your plan premiums</b> 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. <b>You can also</b> <b>choose to pay your premium by having it automatically taken out of your Social Security or Railroad</b> <b>Retirement Board (RRB) benefit each month.</b>				
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.				

Premium Payment Schedule (Choose One - if you don't select a payment option, we will bill you monthly.)				
Please see below for further information regarding paying your premium. <b>Do not send money now.</b> If your application is approved, we will bill you based on the payment schedule below.				
I would like to be billed:				
<ul> <li>Get a bill monthly. Pay by mail (check, money order or MoneyGram).</li> <li>Pay by phone monthly. You can also call Customer Service to make a payment by phone using your checking account. You will need to provide your routing number and checking account number that are printed on the bottom of your checks.</li> <li>Pay online monthly by logging on to the Member Portal at BravenHealth.com.</li> <li>Go to the "Payment Center" tab.</li> <li>Provide the requested information.</li> </ul>	<ul> <li>Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check:</li> <li>I get monthly benefits from:</li> <li>Social Security</li> <li>RRB</li> <li>(The Social Security/RRB deduction may take two or more months to begin after Social Security or the RRB approves the deduction. In most cases, if Social Security or the RRB accepts your request for automatic deduction, the first deduction from your Social Security or the RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or the RRB does not approve your request for automatic deduction we</li> </ul>			

Agent Use Only
GA ID: GA Receipt Date:// NPN#
Name of Broker:
Receipt Date:   ////////////////////////////////////
Email Address:
Requested Effective Date of Coverage:   ////////////////////////////////////
Opportunity ID:    Location ID:    Consumer ID:
Event ID:

will send you a paper bill for your monthly premiums.)

#### PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

# 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.

I am new to Medicare.	I recently left a PACE program on (insert date)		
I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).	<ul> <li>I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug</li> </ul>		
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)	coverage on (insert date) I am leaving employer or union coverage on (insert date)		
I recently was released from incarceration. I was released on (insert date)	I belong to a pharmacy assistance program provided by my state. (check one)		
☐ I recently returned to the United States after living permanently outside the U.S. I returned to the U.S. on	Pharmaceutical Assistance to the Aged and Disabled (PAAD)		
(insert date)	Senior Gold (SG)		
☐ I recently obtained lawful presence status in the United States. I got this status on (insert date)	My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.		
<ul> <li>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)</li> </ul>	☐ 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)		
<ul> <li>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)</li> </ul>	□ 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) 		
<ul> <li>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.</li> </ul>	☐ 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		
I am moving into, live in, or recently moved out of a	enrollment request because of the disaster.		
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)	<ul> <li>I have had Medicare prior to now, but am now turning 65.</li> <li>None of these statements apply to me.<sup>†</sup></li> </ul>		
<sup>†</sup> If none of these statements applies to you or you're not sure, r	please contact Braven Health at 1-833-713-1313 to see if you are		

The 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.