2024 MCS Classicare (HMO) Enrollment Request Form

Effective Date (MM/DD/YYYY): ___________________________________ **SOA #**: __________________

Select the plan you want to join:

☐MCS Classicare Del Caribe (HMO) PBP 057
☐MCS Classicare Efectivo (HMO) PBP 005
☐MCS Classicare En Tu Hogar (HMO) PBP 043
☐MCS Classicare Essential (HMO-POS) PBP 008
☐MCS Classicare Exacto (HMO) PBP 053
☐MCS Classicare Excede (HMO) PBP 056:
 ☐ Region **1** ☐ Region **2**
☐MCS Classicare Firme (HMO) PBP 042
☐MCS Classicare Hero (HMO) PBP 044
☐MCS Classicare InteliCare (HMO) PBP 052
☐MCS Classicare Metro (HMO) PBP 051
☐MCS Classicare Patriot (HMO) PBP 016
☐MCS Classicare Primero (HMO C-SNP) PBP 038
☐MCS Classicare Platino Del Sur (HMO D-SNP) PBP 055
☐MCS Classicare Platino Ideal (HMO D-SNP) PBP 002
☐MCS Classicare Platino Máximo (HMO D-SNP) PBP 054:
 ☐ Region **1** ☐ Region **2** ☐ Region **3**
☐MCS Classicare Platino MásCa$h (HMO D-SNP) PBP 029
☐MCS Classicare Platino Progreso (HMO D-SNP) PBP 017
☐MCS Classicare Platino Total (HMO D-SNP) PBP 046

$0 monthly premium (all plans)

Previous medical plan:

___ MMM ___ SSS ___ Humana ___ Original Medicare ___ Other, specify: ____________________

Beneficiary Information:

Last name:____ **Name**:_________________________ **Initial**:______

Birth Date (MM/DD/YYYY):__________________________ **Sex:** Male ________ Female________

Home phone number: ____________________________ **Alternate phone number**:______________________

Permanent Residence address (Urbanization or Condominium). PO Box is not allowed:

____

House or Apartment Number: ______________________ Street Name or Number: ______________________

City: ____ State: PR Zip Code (ZIP + 4 Code): __________

Mailing Address (Urbanization or Condominium), if different from your permanent address.

____

House or Apartment Number: ______________________ Street Name or Number: ______________________

City: ____ State: PR Zip Code (ZIP + 4 Code): __________

Answering the following two questions is optional. You can't be denied coverage because you don't fill them out.

1. Are you Hispanic, Latino(a), or Spanish origin? Select all that apply.
 __ Yes, Puerto Rican
 __ Yes, Mexican, Mexican American, Chicano(a)
 __ Yes, Cuban
 __ Yes, another Hispanic, Latino(a), or Spanish origin
 __ No, not of Hispanic, Latino(a), or Spanish origin
 __ **I choose not to answer**.

2. What's your race? Select all that apply.

__ White
__ Black or African American
__ American Indian or Alaska Native

Native Hawaiian and Pacific Islander:
__ Guamanian or Chamorro
__ Native Hawaiian
__ Samoan
__ Other Pacific Islander

Asian:
__ Asian Indian
__ Chinese
__ Filipino
__ Japanese
__ Korean
__ Vietnamese
__ Other Asian

__ **I choose not to answer**.

Your Medicare Information:

Name (as it appears on your Medicare card): ____________________________________

Medicare Number: ____________________________________

Hospital (Part A) Effective Date (MM/DD/YYYY): ____________________________________

Medical (Part B) Effective Date (MM/DD/YYYY): ____________________________________

Paying Your Plan Premium:

For all plans, except MCS Classicare Platino (HMO D-SNP): If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail, with debit and credit cards (ATH, American Express, Mastercard or Visa), money order or by check in the Service Centers. Also, you may pay by phone through our Service Call Center or in our website, 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 MCS Classicare (HMO) the Part D-IRMAA.

There are programs in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your local Medical Assistance (Medicaid) office to find out more about their rules. Or call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week and say "Medicaid" for more information. TTY users should call 1-877-486-2048. You can also visit https://www.medicare.gov for more information.

Premium Payment Method, if applicable:

If you don't select a payment option, you will get a coupon book.

Please select a premium payment option:

__ Get a coupon book for payment (L) through any Banco Popular branch, by mail or in any Service Center.

__ Automatic withdrawal from your bank account each month (P). Please include a VOIDED check or provide the following:

Account holder name: ____________________________________

Bank routing number: ______________________ Bank account number: ______________________

Account type: Checking ________ Savings________

__ Automatic deduction from your monthly Social Security (W) 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 accept 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.)

— You can make your payment through our website. To use the service, you should: a) Access www.mcsclassicare.com. b) Once you access the page, you will see an option on the center of the screen titled "My MCS." Click on the link. c) You will see a box to the right side of the screen. If you are a new user, you must sign up. Click on "Register." d) Once you have logged in to the registration page, complete the "Registration Form." You will need your plan's identification card. Have it on hand. When your payment is done, the system will give you a confirmation number.

Answer these Important Questions:

1. Are you new to Medicare? **Yes** ____ **No** ____
2. Are you enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP)? **Yes** ____ **No** ____
3. Have you recently moved from your current plan's service area, and this plan is a new option for you?
   Yes ____ **No** ____ If "Yes" please provide the date you moved on: ______________________________
   If "Yes," MCS Advantage becomes aware of your move on the date this application is signed.
4. Are you enrolled in the State Medicaid Program or have you recently received Medicaid? **Yes** ____ **No** ____
   If "Yes", please provide your Medicaid Number (MPI): ________________
5. Were you enrolled in a Special Needs Plan C-SNP or D-SNP, but you lost the special need qualification required to be in that plan? **Yes** ____ **No** ____
   If "Yes", please provide the date you were notified of the loss of eligibility: ____________________________
6. Did you recently involuntarily lose your creditable prescription drug coverage, coverage as good as Medicare's (i.e. employer or union coverage)? **Yes** ____ **No** ____
   If "Yes", please provide the date when you lost the prescription drug coverage: ________________________
7. Are you leaving employer or union coverage? **Yes** ____ **No** ____
   If "Yes", please provide the date: ____
8. Is your plan ending its contract with Medicare, or is Medicare ending its contract with your plan?
   Yes ____ **No** ____
9. Were you released from incarceration recently? **Yes** ____ **No** ____
   If "Yes", please provide the date you were released from the institution: _______________________________
10. Have you obtained lawful presence status in the United States recently? **Yes** ____ **No** ____
    If "Yes", please provide the date you obtained lawful presence status: _________________________________
11. Were you affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)? One of the other statements here applied to you, but you could not make your enrollment because of the natural disaster. **Yes** ____ **No** ____
12. Were you enrolled in a plan by Medicare (or state) and you want to choose a different plan? **Yes** ____ **No**____
    If "Yes", please provide the start date on that plan: ____

13. If you selected **MCS Classicare Primero (HMO C-SNP)**, please indicate which chronic condition you were diagnosed with:

    Diabetes Mellitus ____ **Congestive Heart Failure** ____

    Cardiovascular Disorder: Cardiovascular arrhythmias, Coronary artery disease, Peripheral vascular disease or Chronic venous thromboembolic disorder ____

14. Do you or your spouse work? **Yes** ____ **No** ____

Giving us your VA benefits private information is voluntary. VA eligibility will not affect your Medicare or MCS Classicare (HMO) eligibility or enrollment.

15. Are you a Veteran? **Yes** ____ **No** ____

16. Are you the spouse of a Veteran? **Yes** ____ **No** ____

17. Some people may have other medical / hospital or drug insurance coverage, including other private insurance, Worker's compensation, VA benefits, TRICARE or Federal Employee Health Benefits. Do you personally, or through your spouse, have or will have another medical/hospital insurance or prescription drug coverage in addition to MCS Classicare (HMO), such as a private insurance, TRICARE, Federal Employee Health Benefits Coverage, Veterans Benefits or State pharmaceutical assistance programs? **Yes** ____ **No** ____

    If "Yes", please provide us with your other coverage and identification number for this coverage:
    Name of Plan:____________________ Contract Number:____________________
    Employer's Name:____________________ Group Number:____________________
    Look on your other prescription drug plan card to complete the following information:
    Rx Bin:______________ Rx PCN:______________ Rx Group:______________

18. Do you reside in a long-term care facility, such as a senior center or a nursing home? **Yes** ____ **No** ____
    If "Yes", please provide us the following information:
    Name of the institution: ____________________
    Institution Phone number: ____________________
    Name of the person in charge of the institution: ____________________

19. Do you have Advance Directives? **Yes** ____ **No** ____

<u>Primary Care Physician (PCP) Information</u>:

Please choose the name of a Primary Care Physician (PCP):

Primary Care Physician (PCP) Name: ____________________
Primary Care Physician Group Number: ____________________

<u>Informational Materials</u>:

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

Other Format: Audio CD ____ Braille ____ Large Print ____
Other Language: Spanish ____ Other: ____________________

Please contact our MCS Classicare Service Call Center at 787.620.2530 (Metro Area) or 1.866.627.8183 (Toll Free), if you need information in an accessible format or language other than what's listed above. Our operation hours are Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30. Customer message system is

available for members to leave a message after regular business hours or holidays. TTY users should call 1.866.627.8182 (hearing impaired).

Do you authorize MCS Classicare (HMO) to send you the following documents by email: Providers and Pharmacies Directory, Annual Notice of Changes, Evidence of Coverage, Summary of Benefits, Prescription Drugs Formulary, Durable Medical Equipment Formulary, promotional material, educational material, among other plan communications?

Yes _____ **No** _____

If "Yes", please provide your email address: ____

Do you authorize MCS Classicare (HMO) to send you text messages related to your health services and other communications from the plan?

Yes _____ **No** _____

If "Yes", please provide your cell phone number ____

After enrollment, if you do not wish to receive communications by email or text messages to your cell phone, you can contact our Service Call Center: 787.620.2530 (Metro Area), 1.866.627.8183 (Toll Free). Our operation hours are Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30. Customer message system is available for members to leave a message after regular business hours or holidays. TTY users should call 1.866.627.8182 (hearing impaired).

Read This Important Information:

If you currently have health coverage from an employer or union, joining MCS Classicare (HMO) could affect your employer or union health benefits. **You could lose your employer or union health coverage if you join MCS Classicare (HMO)**. 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.

IMPORTANT: Read and Sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in MCS Classicare (HMO).
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that MCS Classicare (HMO) 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. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that when my MCS Classicare (HMO) coverage begins, I must get all my medical and prescription drug benefits from MCS Classicare (HMO). Benefits and services provided by MCS Classicare (HMO) and contained in my MCS Classicare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor MCS Classicare (HMO) will pay for benefits or services that are not covered.
- 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.

I hereby acknowledge receipt of the following documents provided by Sales Representative or Agent:

- H5577 Plan Ratings
- Advanced Directives
- Multi-Language Insert
- Instructions on how to access the Providers and Pharmacies Directory, the Evidence of Coverage, and the Prescription Drug Formulary, as applicable
- Model of Care (MOC) – **Platino and C-SNP only**
- Summary of Benefits
- Pre-Enrollment Checklist
- Other: ____

I also, certify that the Sales Representative or Agent has oriented me about the Use and/or Disclosure of Protected Health Information Authorization Formulary.

Signature:______________________________ **Today's Date**: ______________________

If you are the authorized representative, sign above and fill out these fields:
Name: ____
Address: ____
____
Phone Number: __________________________ **Relationship to Enrollee**: ________________

MCS Classicare is an HMO plan subscribed by MCS Advantage, Inc.

Office Use Only:
Name staff member/agent/broker: ______________________________
Signature: ____
Agent ID Number: __________________________ Signature Date: ______________________
ICEP/IEP:____ AEP: ____ MA OEP: ____ SEP (type): _____ Not eligible: ____ Plan ID # ______________