Florida Complete Care

Individual Enrollment Request Form - 2022

Section 1 – All fields on this page are required (unless marked optional)			
Select the plan you want to join:			
☐ **Florida Complete Care (HMO I- SNP)** ☐ **Florida Complete Care – In the Community (HMO I- SNP)**			**$34.30 per month** **$34.30 per month**
FIRST name:	LAST name:		[Optional: Middle Initial]:
Birth date: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Sex: ☐ Male ☐ Female	Phone number: ( )	
Email Address:		In addition, may we contact you by ☐ email and/or ☐ text?	
Permanent Residence street address (Don't enter a PO Box):			
City:	[Optional: County]:	State:	ZIP Code:
Mailing address, if different from your permanent address (PO Box allowed) Street address:			
City:	[Optional: County]:	State:	ZIP Code:

Your Medicare information:	
Medicare Effective Date: **Part A Effective Date** **Part B Effective Date**	**Medicare Number:** _ _ _ _ - _ _ _ - _ _ _ _

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Florida Complete Care?

☐ **Yes** ☐ **No**

Name of other coverage:	Member number for this coverage	Group number for this coverage:
_____	_____	_____

Your Medicaid information:

Are you currently enrolled with Medicaid? If yes, complete the information below.

☐ **Yes** ☐ **No**

Medicaid Number (if applicable):	_ _ _ _ _ _ _ _ _ _ _ _

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

Primary Care Provider Information:

Primary Care ID Number (as listed in the Provider Directory):

List Primary Medical Group Name:

Provider First Name:	Provider Last Name:

PCP Street Address:

City:	[Optional: County]:	State:	ZIP Code:

Facility Information

Name:	Phone:

Applicant Name:_____

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.
Select one if you want us to send you information in a language other than English. ☐ Spanish
Select one if you want us to send you information in an accessible format. ☐ Braille ☐ Large print Please contact Florida Complete Care at 1-833-FC2-PLAN (1-833-322-7526) if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. TTY users can call 711.

Applicant Name:_____

Paying your plan premiums

☐ **Send Me A Bill:** You have the option to receive a bill from Florida Complete Care. You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, the check should be made payable to Florida Complete Care, not CMS nor HHS. Please send your check by the 1st of the month to:

Florida Complete Care
Attn: FC2 Finance
PO Box 667870
Miami, Florida 33166

☐ **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.**

Account Type	☐ **Checking** – **May** enclose a VOIDED check or provide the following information	☐ **Savings** – **MUST** enclose a letter from financial institution with account and routing information.

Account Holder Name _____ Bank name _____

Bank routing number* | | | | | | | | | |

(*This is the first 9 digits printed on the lower left corner of your check.)

Bank Account number* | | | | | | | | | | | | | | | | |

I authorize the bank above to deduct my monthly premiums.

Automatic deduction from your monthly ☐ Social Security or ☐ Railroad Retirement Board (RRB) benefit check.

(The Social Security/Railroad Retirement Board (RRB) deduction may take two or more months to begin after Social Security or Railroad Retirement Board (RRB) approves the deduction. In most cases, if Social Security or Railroad Retirement Board (RRB) accepts your request for automatic deduction, the first deduction from your Social Security or Railroad Retirement Board (RRB) benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or Railroad Retirement Board (RRB) delays or does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums).

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 Florida Complete Care the Part D-IRMAA.

Applicant Name:_____

ATTESTATION OF ELIGIBILITY

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 of 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 am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ 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) _____.
- ☐ I recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ☐ 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) _____.
- ☐ 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) _____.
- ☐ 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.
- ☐ 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) _____.
- ☐ I recently left a PACE program on (insert date) _____.
- ☐ OTHER: I have an open enrollment period because I am deemed to have an institutional level of care (OEPI).

Applicant Name:_____

Eligibility Criteria:

Our plan is designed to meet the specialized needs of people who need a level of care that is usually provided in a nursing home.

To be eligible for our plan, you must meet one of the two requirements listed below.

- You live in a nursing home available through our plan.
- You live at home and the State of Florida has certified that you need the type of care that is usually provided in a nursing home.

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Florida Complete Care.
- By joining this Medicare Advantage Plan, I acknowledge that Florida Complete Care 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.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if Iintentionally provide false information on this form, I will be disenrolled from the plan.
- 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.
- I understand that when my Florida Complete Care coverage begins, I must get all of my medical and prescription drug benefits from Florida Complete Care. Benefits and services provided by Florida Complete Care and contained in my Florida Complete Care "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Florida Complete Care will pay for benefits or services that are not covered.
- 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: **X** _____	**Today's date:** _____

If you're the authorized representative, sign above and fill out these fields:

Name:	Address:
Phone number:	Relationship to enrollee:

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 and 1860D-1 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.

Applicant Name:_____

Applicant: Please do not complete the following sections.
Agent/Broker: Please fill in ALL fields including "Writing Agent" and 'Agency' with your assigned Encrypted ID, Code, or Tax ID based on your appointed brand, state AND product.

Coverage effective date _____ Plan ID # _____

I helped the applicant fill out this application. ☐ Yes ☐ No

Was this an individual face-to-face appointment? ☐ Yes ☐ No

If Yes, how was a scope of appointment (SOA) collected?

☐ Paper ☐ Recorded call (voice recording ID)_____

Print Name: First Name Last Name

Writing Agent TIN (10 digits)/Agent Code _ _ _ _ _ _ _ _ _ _

Agent TIN (10 digits) or Agent Code _ _ _ _ _ _ _ _ _ _

Agency Name_____

Phone _____

Email_____@_____

Signature _____ Application received date _____

Applicant Name:_____