Florida Complete Care

Individual Enrollment Request Form – 2024

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)**			**$37.70 per month**
☐ **Florida Complete Care – In the Community (HMO I- SNP)**			**$37.70 per month**
☐ **Florida Complete Care – D-SNP (HMO D-SNP)**			**$37.70 per month**
FIRST name:	LAST name:	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:	County:	State:	ZIP Code:
Mailing address, if different from your permanent address (PO Box allowed): Street address:			
City:	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:	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.

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:

☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Vietnamese
☐ Other Asian

☐ Black or African American

Native Hawaiian and Pacific Islander:

☐ Guamanian or Chamorro
☐ Native Hawaiian
☐ Samoan
☐ Other Pacific Islander

☐ White
☐ **I choose not to answer.**

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

☐ Spanish ☐ Creole ☐ Other_____

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

☐ Braille ☐ Large print ☐ Audio CD

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.

I want to get the following materials via email.

Select one or more.

☐ Summary of Benefits ☐ Evidence of Coverage ☐ Star Ratings
☐ Notice of Privacy Practices ☐ Appointment of Representative ☐ LIS Premium Summary
☐ Over-the-Counter Benefits Catalog
☐ Other_____

E-mail address:

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.

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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. (IEP/ICEP)
- ☐ I am enrolling during the Annual Open Enrollment Period from October 15 to December 7 (AEP).
- ☐ 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) _____. (SEP)
- ☐ 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) _____.
- ☐ I have an open enrollment period because I am deemed to have an institutional level of care (OEPI).
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal state and local government entity. One of the

Applicant Name:_____

other statements here applied to me, but I was unable to make my enrollment request because of the disaster. (SEP).

Other: _____

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Eligibility Criteria:

To be eligible for our plans, you must meet the requirements listed below.

- **(HMO I- SNP)** You live in a nursing home available through our plan.
- **(HMO I- SNP)** 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.
- **(HMO D- SNP)** To enroll in Florida Complete Care Fully Integrated Dual Eligible Special Needs Plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B, live in our service area, receive certain levels of assistance from the Florida Medicaid, and be enrolled in the Florida Community Care Long-Term Care plan.

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 I intentionally 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 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).
- 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

Applicant Name:_____

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: 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:_____

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-833-322-7526. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-833-322-7526. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-833-322-7526。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-833-322-7526。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-833-322-7526. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-833-322-7526. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-833-322-7526 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-833-322-7526. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화1-833-322-7526 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-833-322-7526. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-833-322-7526. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-833-322-7526 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-833-322-7526. Un nostro incaricato che parla

Applicant Name:_____

Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-833-322-7526. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-833-322-7526. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-833-322-7526. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-833-322-7526 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Applicant Name:_____