OMB No. 0938-1378
Expires: 12/31/2026

MODEL INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C) OR MEDICARE PRESCRIPTION DRUG PLAN (PART D)

Who can use this form?

People with Medicare who want to join a Medicare Advantage or Medicare Prescription Drug Plan 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 (Hospital Insurance)
- Medicare Part B (Medical Insurance)

Important: To join a Medicare Prescription Drug Plan, you must also have either, or 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 January1)
- 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:

Florida Complete Care
4601 NW 77th Avenue
Miami, FL 33166

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

How do I get help with this form?

Call Florida Complete Care at 1-833-FC2-PLAN (1-833-322-7526). 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 Florida Complete Care al 1-833-FC2-PLAN (1-833-322-7526)/711 o a Medicare gratis al 1-800-633-4227 y oprima el 8 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.

Florida complete care

2026 Individual Enrollment Request Form

Section 1 – All fields on this page are required (unless marked optional):	
Select the plan you want to join:	**Coverage effective date:** (__ __ /__ __ / __ __ __ __)
☐ **Florida Complete Care (HMO I-SNP)**	**$4.80 per month (Part D premium)/ $0.00 per month (Part C premium)**
☐ **Florida Complete Care – In the Community (HMO-POS I-SNP)**	**$4.80 per month (Part D premium)/ $0.00 per month (Part C premium)**
Florida Complete Care – Duals-VIP (HMO-POS D-SNP) ☐ **Plan 004 – 1** ☐ **Plan 004 – 2** ☐ **Plan 004 – 3**	 **$0.00 (includes Part C and D) per month** **$0.00 (includes Part C and D) per month** **$0.00 (includes Part C and D) per month**

First name:	Last name:	Middle initial:

Birth date: (MM/DD/YYYY) (__ __/__ __/ __ __ __ __)	Sex: ☐ Male ☐ Female	Phone number (___ ___ ___)___ ___ ___ -___ ___ ___ ___

Permanent Residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:	County:	State:	Zip Code:

Mailing address, if different from your permanent address (PO Box allowed):

City:	County:	State:	Zip Code:

Your Medicare Information:

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 _____

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

- (HMO I- SNP) Do you live in a nursing home available through our plan? ☐ Yes ☐ No
  (If yes, enter information below):

Name of Facility:	Address:	City:	State:	Zip Code:

Answer these important questions (continued):

- (HMO-POS I- SNP) Do 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? ☐ Yes ☐ No (If yes, enter information below):

Name of Facility:	Address:	City:	State:	Zip Code:

- (HMO-POS D- SNP) Are you 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? ☐ Yes ☐ No (If yes, enter information below):

Medicaid Number: ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ____

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, 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.
- I understand that I can be enrolled in only one MA or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- 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.
- 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.

Signature:	Today's date:

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

Name:	Address:
Phone number:	Relationship to enrollee:

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 ☐ Creole ☐ Russian ☐ Other_____

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data 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.

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

List your Primary Care Physician (PCP), clinic, or health center:

Address	City	State	Zip Code

I want to get the following materials via email. Select one or more.

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

E-mail address:_____

Paying Your Plan Premiums:

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, by Electronic Funds Transfer (EFT), or by credit card each month, etc. **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. DON'T pay Florida Complete Care the Part D-IRMAA.

Please select one option below:

☐ By mail – You will receive a montly invoice.
☐ By Electronic Funds Transfer (EFT) – We will send you a separate authorization form to collect your bank information.
☐ By credit card – We will send you a separate authorization form to collect your card information.
☐ By deduction from your monthly Social Security benefit check.
☐ By deduction from your monthly Railroad Retirement Board (RRB) benefit check

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____

Relationship to enrollee: _____

Signature: _____

National Producer Number (Agents/Brokers only): _____

Other administrative information needed by plan: _____

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).

Attestation of Eligibility (continued)

- ☐ 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 Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans called an integrated Dual Eligible Special Needs Plan (D-SNP).
- ☐ 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 other statements here applied to me, but I was unable to make my enrollment request because of the disaster. (SEP).

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 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.