



Individual Enrollment Request Form to Enroll in a Medicare Advantage Plan (Part C)

Who can use this form?

People with Medicare who want to join a Medicare Advantage 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 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](https://www.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:

Mail: Ultimate Health Plans

PO Box 3459

Spring Hill, FL 34611

Fax: 352-515-5969

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

How do I get help with this form?

Call Ultimate Health Plans at 1-855-858-7526. 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 Ultimate Health Plans al 1-855-858-7526 (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.



To Enroll in Ultimate Health Plans, Please Provide the Following Information

Section 1 – All fields in this section are required (unless marked optional)

Select the plan you want to join (all plans are \$0 additional plan premium per month):

Citrus County

- 013-4 Premier by Ultimate (HMO)
- 032 Premier Plus by Ultimate (HMO)
- 021 Advantage Care by Ultimate (HMO C-SNP)
- 022 Advantage Care CHF by Ultimate (HMO C-SNP)
- 023 Advantage Care COPD by Ultimate (HMO C-SNP)
- 035 Advantage Plus by Ultimate (Full) (HMO D-SNP)
- 036 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

Hernando County

- 001 Premier by Ultimate (HMO)
- 032 Premier Plus by Ultimate (HMO)
- 019-1 Advantage Care by Ultimate (HMO C-SNP)
- 024 Advantage Care CHF by Ultimate (HMO C-SNP)
- 025 Advantage Care COPD by Ultimate (HMO C-SNP)
- 035 Advantage Plus by Ultimate (Full) (HMO D-SNP)
- 036 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

Hillsborough & Pinellas Counties

- 045 Premier by Ultimate (HMO)
- 026 Advantage Care by Ultimate (HMO C-SNP)
- 025 Advantage Care COPD by Ultimate (HMO C-SNP)
- 035 Advantage Plus by Ultimate (Full) (HMO D-SNP)
- 036 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

Indian River & St. Lucie Counties

- 031 Premier by Ultimate (HMO)
- 032 Premier Plus by Ultimate (HMO)
- 033 Advantage Care by Ultimate (HMO C-SNP)
- 034 Advantage Care COPD by Ultimate (HMO C-SNP)
- 035 Advantage Plus by Ultimate (Full) (HMO D-SNP)
- 036 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

Lake, Marion, & Sumter Counties

- 028 Premier by Ultimate (HMO)
- 029 Advantage Care by Ultimate (HMO C-SNP)
- 023 Advantage Care COPD by Ultimate (HMO C-SNP)
- 035 Advantage Plus by Ultimate (Full) (HMO D-SNP)
- 036 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

Manatee & Sarasota Counties

- 047 Premier by Ultimate (HMO)
- 052 Advantage Care by Ultimate (HMO C-SNP)
- 034 Advantage Care COPD by Ultimate (HMO C-SNP)
- 035 Advantage Plus by Ultimate (Full) (HMO D-SNP)
- 036 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

Orange, Osceola, & Seminole Counties

- 046 Premier by Ultimate (HMO)
- 050 Advantage Care by Ultimate (HMO C-SNP)
- 034 Advantage Care COPD by Ultimate (HMO C-SNP)
- 035 Advantage Plus by Ultimate (Full) (HMO D-SNP)
- 036 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

Pasco County

- 013-3 Premier by Ultimate (HMO)
- 032 Premier Plus by Ultimate (HMO)
- 019-2 Advantage Care by Ultimate (HMO C-SNP)
- 024 Advantage Care CHF by Ultimate (HMO C-SNP)
- 025 Advantage Care COPD by Ultimate (HMO C-SNP)
- 035 Advantage Plus by Ultimate (Full) (HMO D-SNP)
- 036 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

Polk County

- 045 Premier by Ultimate (HMO)
- 051 Advantage Care by Ultimate (HMO C-SNP)
- 034 Advantage Care COPD by Ultimate (HMO C-SNP)
- 035 Advantage Plus by Ultimate (Full) (HMO D-SNP)
- 036 Advantage Plus by Ultimate (Partial) (HMO D-SNP)

FIRST NAME:

LAST NAME:

MI:

BIRTH DATE:

PHONE NUMBER:

SEX:

Male

Female

PERMANENT RESIDENCE STREET ADDRESS (Don't enter a PO Box):

CITY:

STATE:

ZIP CODE:

COUNTY (Optional):

MAILING ADDRESS (If different from your Permanent Address – PO Box allowed):

Grid for mailing address

CITY:

Grid for city

STATE:

Grid for state

ZIP CODE:

Grid for zip code

Your Medicare Information:

MEDICARE NUMBER:

Grid for Medicare number

Answer These Important Questions:

1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Ultimate Health Plans?

Yes No

NAME OF OTHER COVERAGE:

Grid for name of other coverage

MEMBER NUMBER FOR THIS COVERAGE:

GROUP NUMBER FOR THIS COVERAGE:

Grid for member number

Grid for group number

2. Answer Only for C-SNP plans (019, 021, 022, 023, 024, 025, 026, 029, 033, 034, 050, 051, 052):

Do you have one of the following conditions: Cardiovascular Disease (CVD), Chronic Heart Failure (CHF), Chronic Lung Disorder/COPD, Diabetes Mellitus (DM)

Yes No

If "yes," please also fill out the Chronic Special Needs Plan (C-SNP) Pre-Qualification Form.

3. Answer Only for D-SNP plans (035, 036):

Are you currently actively enrolled in the State of Florida Medicaid program?

Yes No

If "yes", please provide your Florida Medicaid number:

Grid for Florida Medicaid number

IMPORTANT: Please Read and Sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Ultimate Health Plans.
By joining this Medicare Advantage Plan, I acknowledge that Ultimate Health Plans will share my information with Medicare...
I understand that I can be enrolled in only one MA plan at a time...
I understand that when my Ultimate Health Plans coverage begins, I must get all of my medical and prescription drug benefits from Ultimate Health Plans.
The information on this enrollment form is correct to the best of my knowledge.
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.
1. This person is authorized under State law to complete this enrollment, and
2. Documentation of this authority is available upon request by Medicare.

TODAY'S DATE:

Grid for today's date

SIGNATURE:

Grid for signature

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

FIRST NAME:

Grid for first name

LAST NAME:

Grid for last name

MI:

Grid for middle initial

ADDRESS:

Grid for address

RELATIONSHIP TO ENROLLEE:

Grid for relationship to enrollee

PHONE NUMBER:

Grid for phone number

Section 2 – All fields in this section are optional

Answering these questions is your choice. 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.

- 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

2. 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

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

- Spanish

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

- Braille
- Large Print
- Audio CD

Please contact Ultimate Health Plans at 1-888-657-4170 if you need information in an accessible format other than what's listed above. Our office hours are Monday through Sunday from 8:00 am - 8:00 pm EST. During certain parts of the year we may use alternative technologies to answer your call on weekends and Federal holidays. TTY users can call 711.

5. Do you work?

- Yes
- No

6. Does your spouse work?

- Yes
- No

7. List your Primary Care Physician (PCP):

PCP LAST NAME:

PCP FIRST NAME:

PROVIDER ID NUMBER:

Are you an existing patient? Yes No

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

- Plan Communications
- Annual Notice of Change (ANOC)
- Marketing Information

EMAIL 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 or credit card each month. **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 Ultimate Health Plans the Part D-IRMAA.

Office Use Only:

NAME OF STAFF MEMBER/AGENT/BROKER (if assisted in enrollment):

UCAIN/Writing Number:

EFFECTIVE DATE OF COVERAGE:

ELECTION TYPE: ICEP/IEP AEP OEP SEP

PLAN RECEIVED DATE:

ATTACHED DOCUMENTS:

- Scope of Appointment Form ***Required for Agent Assisted Enrollments**
- Attestation of Eligibility Form ***Required for All Enrollments Except AEP**
- Chronic SNP Pre-Qualification Form ***Required for C-SNP Enrollments**
- Other: _____

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.