DOCTORS HEALTHCARE PLANS, INC.

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 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:

Doctors HealthCare Plans, Inc.
Attention: Enrollment Department
2020 Ponce de Leon Blvd., PH1
Coral Gables, FL 33134

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

HOW DO I GET HELP WITH THIS FORM?

Call Doctors HealthCare Plans, Inc. directly at (786) 460-3427 or toll free at (833) 342-7463. 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 Doctors HealthCare Plans, Inc. al (786) 460-3427 o al (833) 342-7463, 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 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-NEW. 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.

DOCTORS HEALTHCARE PLANS, INC.

PROPOSED EFFECTIVE DATE

ENROLLMENT REQUEST FORM

All fields on this page are required (unless marked optional).

SELECT THE PLAN YOU WANT TO JOIN

MIAMI-DADE PLANS

- ☐ **DrMax** (HMO) H4140-001
- ☐ **DrPlus** (HMO D-SNP) H4140-002
- ☐ **DrExtraCare** (HMO C-SNP) H4140-004
- ☐ **DrValue** (HMO) H4140-005
- ☐ **DrSelect** (HMO) H4140-012
- ☐ **DrFlex** (HMO D-SNP) H4140-013

BROWARD PLANS

- ☐ **DrMax-B** (HMO) H4140-009
- ☐ **DrPlus-B** (HMO D-SNP) H4140-010
- ☐ **DrElite-B** (HMO) H4140-014

SECTION 1 — ALL FIELDS ON THIS PAGE ARE REQUIRED (UNLESS MARKED OPTIONAL)

LAST Name | FIRST Name | Middle Initial (optional)

Birth Date (mm/dd/yyyy)	Sex ☐ M ☐ F	Phone Number ( )	Cell Phone ( )

Permanent Residence Street Address (Do not enter a PO Box) | Apt. #

City | County (optional) | State | ZIP Code

Email

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

Street Address | City | State | ZIP Code

By providing an email and telephone number you consent to receiving autodialed and pre-recorded or artificially-voiced healthcare communications, informational and marketing communications, as well as text messages. You can withdraw consent at any time by calling Member Services at (833) 342-7463.

YOUR MEDICARE INFORMATION

Medicare Number _____ _____ _____ _____ – _____ _____ _____ – _____ _____ _____ _____

EMERGENCY CONTACT

Name	Phone	Relationship to You

ANSWER THESE IMPORTANT QUESTIONS

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Doctors HealthCare Plans, Inc.

☐ Yes ☐ No If "Yes" please list your other coverage and your (ID) number(s) for this coverage:

Name of other coverage	Member number for this coverage	Group number for this coverage
. . . . .	. . . . .	. . . . .

If applying for a Special Needs Plan, please select one below:

» If you are enrolling in the **DrExtraCare** Plan, do you have: ☐ Chronic Heart Failure ☐ Diabetes Mellitus

» If you are enrolling in the **DrPlus, DrFlex** or **DrPlus-B** Plan, insert your **Medicaid Number**: . . . . . .

IMPORTANT: READ AND SIGN BELOW

» I must keep both Hospital (Part A) and Medical (Part B) to stay in Doctors HealthCare Plans, Inc.

» By joining this Medicare Advantage Plan, I acknowledge that Doctors HealthCare Plans, Inc. 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 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 when my Doctors HealthCare Plans, Inc. coverage begins, I must get all of my medical and prescription drug benefits from Doctors HealthCare Plans, Inc. Benefits and service provided by Doctors HealthCare Plans, Inc. and contained in my Doctors HealthCare Plans, Inc. "Evidence of Coverage" documents (also know as a member contract or subscriber agreement) will be covered. Neither Medicare nor Doctors HealthCare Plans, Inc. 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
. . . . .	. . . . .

Witness Signature (if applicable)	Today's Date
. . . . .	. . . . .

IF YOU'RE THE AUTHORIZED REPRESENTATIVE, SIGN ABOVE AND FILL OUT THESE FIELDS

Name (Print)	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.

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:
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ 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.**

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: ☐ Audio CD ☐ Braille ☐ Large Print

Please contact Doctors HealthCare Plans, Inc. at (833) 342-7463 if you need information in an accessible format other than what's listed above. Our Member Services hours are 7 days a week, from 8AM to 8PM EST. 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:

Primary Care Physician Name (PCP) . . . . . Primary Care Physician ID Number . . . . .

I want to get the following materials via email (select one or more):

☐ Evidence of Coverage ☐ Summary of Benefits ☐ Provider Directory ☐ Specific Letters as Requested

E-mail Address: . . . . .

PAYING YOUR PLAN PREMIUMS

You can pay your monthly premium, including any late enrollment penalty that you currently have or may owe, by mail 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.**

☐ By mail each month

☐ Automatic deduction from your monthly Social Security benefit

☐ Automatic deduction from your monthly Railroad Retirement Board (RRB) benefit

If you have 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 Doctors HealthCare Plans, Inc. the Part D-IRMAA.

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.

TO BE COMPLETED BY A DOCTORS HEALTHCARE PLANS, INC. LICENSED SALES AGENT

Licensed Sales Agent Name (if assisted in enrollment)

Agency Affiliation

Today's Date

Licensed Sales Agent Signature

Licensed Sales Agent Number

LICENSED SALES AGENT — USE THE FOLLOWING CODES FOR APPOINTMENT TYPE

☐ DHCP Portal
☐ Paper Application
☐ Secure Email Application
☐ Telephonic Enrollment
☐ Faxed Application
☐ Mail-in

Doctors HealthCare Plans, Inc. is an HMO plan with a Medicare contract and a contract with the State of Florida Agency for Health Care Administration. Enrollment in Doctors Health Care Plans, Inc. depends on contract renewal.

CODE	ENROLLMENT PERIOD STATEMENTS
☐ IEP/ICEP (Part B)	I am new to Medicare.
☐ AEP-A	Annual Election Period.
☐ MAOEP-M	I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
☐ SEP-V	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-V	I recently was released from incarceration. I was released on _____ (insert date).
☐ SEP-V	I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on _____ (insert date).
☐ SEP-U	I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid).
☐ SEP-U	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).
☐ SEP-L	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.
☐ SEP-T	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).
☐ S 01	I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency [FEMA] or by a Federal, state or local government entity.) One of the other statements here applied to me, but I was unable to make my enrollment request because of the natural disaster.
☐ S 11	My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
☐ S 22	I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on _____ (insert date).
☐ S 27	I recently left a PACE program on _____ (insert date).
☐ S 30	I am applying for a SNP Chronic Condition Plan.
☐ S 35	I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on _____ (insert date).
☐ S 37	I recently obtained lawful presence status in the United States. I got this status on _____ (insert date).
☐ LECW	I am leaving my employer or union overage on _____ (insert date).
☐ OTH	None of these statements apply to me; however, I feel that I am eligible due to a special circumstance which would allow an exception to enroll (subject to approval). _____ (Please explain)

If none of these statements applies to you or you are not sure, please contact Doctors HealthCare Plans, Inc. at (833) 342-7463. If you need information in an accessible format or language other than what is listed above, please call our Member Services Department, hours are 7 days a week, from 8AM to 8PM EST. TTY users should call (711).