OMB No. 0938-1378
Expires: 6/30/2026

Section 1 – All fields on this page are required (unless marked optional)

To Enroll in an Independent Health group plan, please provide the following information:

Employer or Union Name:_____ Group #:_____

Effective Date:_____ Plan Name:_____

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:	State:	Zip Code:

Mailing address, if different from your permanent address (PO Box allowed):
Street address: City: 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 Independent Health?
☐ Yes ☐ No

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

_____ _____ _____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Independent Health.
- By joining this Medicare Advantage, I acknowledge that Independent Health 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 Independent Health coverage begins, I must get all of my medical and prescription drug benefits from Independent Health. Benefits and services provided by Independent Health and contained in my Independent Health "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Independent Health 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 in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you a retiree? ☐ Yes ☐ No
If yes, retirement date (month/day/year):_____
If no, name of retiree:_____

Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No
If yes, name of spouse:_____
Name(s) of dependent(s):_____

Do you or your spouse work? ☐ Yes ☐ No

Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
If "yes" please provide the following information:
Name of Institution:_____
Address & Phone Number of Institution (number and street):_____
_____

Please choose a Primary Care Physician (PCP) from the Provider Directory (note: required for all plans):
Physician's Last Name_____ Physician's First Name_____
Phsyician's Address_____Current Patient ☐ Yes ☐ No

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
  - ☐ 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**.

What is your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____
- ☐ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ I don't know
- ☐ **I choose not to answer**

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Independent Health at (716) 250-4401 or 1-800-665-1502 if you need information in an accessible format other than what's listed above. Our office hours are Our office hours are October 1 – March 31: Monday – Sunday, 8 a.m. – 8 p.m.; April 1- September 30: Monday – Friday, 8a.m.-8p.m.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:

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

☐ Annual Notice of Change ☐ Explanations of Benefits

E-mail address:

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): _____

OFFICE USE ONLY Name of staff member/agent/broker (if assisted in enrollment):_____

Effective Date of Coverage:_____ Location:_____

Plan ID #:_____ ICEP/IEP: _____ AEP: _____ SEP (type): _____ OEP: _____ OSD: _____