2024 CHRISTUS Health Plan Medicare Advantage Plan Application

Who can use this form?
People with Medicare who want to join a Medicare Advantage plan or Medicare Prescription Drug 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 Numbers (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:
CHRISTUS Health Advantage (HMO)
5101 N. O'Connor Blvd. | Irving | TX 75062

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

How do I get help with this form?
Call CHRISTUS Health Plan (HMO) at 844.282.3026. 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 CHRISTUS Health Plan (HMO) al 844.282.3026, TTY 711 o a Medicare gratis al 1.800.633.4227 y oprima el 2 para asistencia an 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 where you receive mail (e.g., social security checks) may be considered your permanent residence address.

CHRISTUS Health Plan

Name of Plan You are Enrolling In: _____

Name:	Medicare Number or Member Number:
_____	_____

Home Phone Number:

Permanent Street Address (P.O. Box is not allowed)

City	County	State	Zip Code

Mailing Address (only if different from your Permanent Street Address):

Street Address City State Zip Code

Please fill out the following. I am currently a member of:

____ CHRISTUS Health Plan Generations (HMO) with a monthly premium of $_____.
____ CHRISTUS Health Plan Generations Plus (HMO) with a monthly premium of $_____.
____ CHRISTUS Health Plan Guardian (HMO) with a monthly premium of $_____.
____ CHRISTUS Health Medicare Complete (HMO) with a monthly premium of $_____.
____ CHRISTUS Health Medicare Plus (HMO) with a monthly premium of $_____.
____ CHRISTUS Health Medicare Guardian (HMO) with a monthly premium of $_____.

I would like to change to the:

____ CHRISTUS Health Medicare Complete (HMO). I understand that this plan has different health benefits and a monthly premium of $_____.**Only available in the following counties: Camp, Cass, Cherokee, Franklin, Gregg, Harrison, Henderson, Hopkins, Marion, Morris, Panola, Red River, Rusk, Smith, Titus, Upshur, Van Zandt and Wood.**
____ CHRISTUS Health Medicare Plus (HMO). I understand that this plan has different health benefits and a monthly premium of $_____.
____ CHRISTUS Health Medicare Guardian (HMO). I understand that this plan has different health benefits and a monthly premium of $_____. It also includes a Part B rebate.

Name of Chosen Primary Care Provider (PCP): _____

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

☐ Spanish ☐ Braille ☐ Large print

Please contact CHRISTUS Health Plan at **844.282.3026** if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. to 8 p.m., local time, 7 days a week, Oct 1 – Mar 31; and 8 a.m. to 8 p.m., local time, Mon – Fri, Apr 1 – Sept 30. TTY users should call 711.

CHRISTUS Health Plan

Your Plan Premium
If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay it by mail. You can also pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. Do NOT pay CHRISTUS Health Plan the Part D-IRMAA. You can pay your monthly premium (including any late enrollment penalty that you currently have or may owe) by mail. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month. If you are assessed a Part D-Income Related Month Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board. Do NOT pay CHRISTUS Health Plan the Part D-IRMAA. People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at **800.772.1213**. TTY users should call **800.325.0778**. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. If you don't select a payment option, you will get a bill each month. Please select a premium payment option: ☐ Get a bill ☐ Automatic deduction from your monthly Social Security or RRB benefit check. I get monthly benefits from: ☐ Social Security ☐ RRB (The Social Security deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for

automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

Please Read and Sign Below
CHRISTUS Health Plan is a plan that has a contract with the Federal government. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with CHRISTUS Health Plan, he/she may be paid based on my enrollment in CHRISTUS Health Medicare Complete (HMO), Medicare Plus (HMO), or Medicare Guardian (HMO) . Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that CHRISTUS Health Plan will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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 aren't covered under Medicare while out of the country except for limited coverage near the U.S. border. I understand that beginning on the date CHRISTUS Health Medicare Complete (HMO), Medicare Plus (HMO), or Medicare Guardian (HMO) coverage begins, I must get all of my health care from CHRISTUS Health Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by CHRISTUS Health Plan and other services contained in my CHRISTUS Health Plan Medicare Complete (HMO), Medicare Plus (HMO), or Medicare Guardian (HMO) Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR CHRISTUS HEALTH PLAN WILL PAY FOR THE SERVICES. I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (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 from Medicare.

Signature:	Today's Date:

CHRISTUS® Health Plan

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

_____

Phone Number: _____

Relationship to Enrollee: _____

Answering these questions is your choice. You can't be denied coverage because you don't fill them out. (Please click the applicable check box.)

Are you Hispanic, Latino/a, Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Chinese
- ☐ Japanese
- ☐ Other Asian
- ☐ Vietnamese
- ☐ **I choose not to answer.**
- ☐ Asian Indian
- ☐ Filipino
- ☐ Korean
- ☐ Other Pacific Islander
- ☐ White
- ☐ Black or African American
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan

Office Use Only:

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

Plan ID#: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not eligible: _____

Where did this application originate?

☐ Clinic ☐ In-Home Appointment ☐ Event ☐ Office ☐ Other