2026 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 aMedicare 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 three 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 Plan
ATTN; Eligibility Department
5101 N. O'Connor Blvd., Irving, TX 75039
Once they process your request to join, they'll contact you.

How do I get help with this form?

Call CHRISTUS Health Plan Medicare Advantage 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 Medicare Advantage 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.

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.

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Please check the plan that you want:

- ☐ CHRISTUS Health Medicare Plus (HMO) Plan 002 ($0 premium)
- ☐ CHRISTUS Health Medicare Complete (HMO) Plan 003 ($0 premium)
- ☐ CHRISTUS Health Medicare Plus (HMO) Plan 004 ($20 premium)
- ☐ CHRISTUS Health Medicare Plus (HMO) Plan 005 ($0 premium)
- ☐ CHRISTUS Health Medicare Plus (HMO) Plan 009 ($0 premium)
- ☐ CHRISTUS Health Medicare Plus (HMO) Plan 010 ($0 premium)
- ☐ CHRISTUS Health Medicare Guardian (HMO) Plan 007 ($0 premium)
- ☐ CHRISTUS Health Medicare Guardian (HMO) Plan 008 ($0 premium)

Please contact CHRISTUS Health Plan if you need information in another language or format (Braille).

To enroll in one of CHRISTUS Health Plan's Medicare Advantage (HMO) plans, please provide the following:			
Last name / First name / Middle initial			Mr. ☐ Mrs. ☐ Ms. ☐
Date of birth (mm/dd/yyyy)	Sex: M ☐ F ☐	Home phone	Alternate phone
Permanent residence address (P.O. Box is NOT allowed)			
City	State	County	Zip code
Mailing address (only if different than permanent residence address)			
Emergency contact information Name: Phone number:		Relationship to you:	
Email: *(Optional)*			

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Please provide your Medicare insurance information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card

OR

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare number: _____

Is entitled to: _____

Hospital (Part A) effective date: _____

Medical (Part B) effective date: _____

You must have Medicare Parts A and B to join a Medicare Advantage Plan.

Paying 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 by mail. You can also choose to 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 Amount (IRMAA), 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 with-held from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay CHRISTUS Health Plan the Part DIRMAA.

If the plan you selected has a premium, you can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT) or credit card. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

People with limited incomes may qualify for *Extra Help* to pay for their prescription drug costs. If eligible, 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 will not be subject to a late enrollment penalty. Many people are eligible 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 costs, Medicare will pay all of your plan premium.

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 Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security | RRB 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 withholdings begin. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Applicant name: _____

Applicant Medicare number: _____

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Please read and answer these important questions

1. Some individuals may have other drug coverage, including private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State Pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to CHRISTUS Health Plan? ☐ Yes ☐ No

If yes, please list your other coverage and your identification (ID) number(s) for this coverage.

Name of coverage ID	# for coverage	Group # for coverage

2. Are you a resident in a long-term care facility, such as a nursing home? If yes, please provide the following information: ☐ Yes ☐ No

Name of institution: _____

Address: _____

Phone number: _____

3. Are you enrolled in your state Medicaid program? ☐ Yes ☐ No

If yes, please provide your Medicaid #: _____

4. Do you or your spouse work? ☐ Yes ☐ No

Provider | PCP full name: _____

Phone number: _____

Provider | PCP full name: _____

Are you currently seeing or have you recently seen this provider? ☐ Yes ☐ No

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 ☐ Audio CD ☐ Data CD

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, seven days a week, Oct. 1 – Mar. 31 and Monday through Friday, Apr. 1 – Sept. 30. TTY users should call **711**.

Applicant name: _____

Applicant Medicare number: _____

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STOP

Please read this important information.

If you currently have health coverage from an employer or union, joining CHRISTUS Health Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join CHRISTUS Health Plan.

Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Agreements

You must read the disclosures below and check the box to confirm you have done so.
Please read this important information.
By completing this enrollment form, I agree to the following:
If I am enrolling in a Medicare Advantage health plan that has a contract with the federal government, I must keep both Hospital Part A and Medical Part B to stay in CHRISTUS Health Medicare Complete (HMO). I must continue to pay my Medicare Part B premium. It is my responsibility to inform CHRISTUS Health Plan of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. With few exceptions, I can only be in one Medicare Advantage health plan or Medicare prescription drug plan at a time. I understand that my enrollment in my selected plan may end my enrollment in another Medicare Advantage health plan or prescription drug plan. Enrollment in my selected plan is generally for the entire year.
I understand that when my CHRISTUS Health Plan coverage begins, I must get all of my medical and prescription drug benefits from CHRISTUS Health Plan. Benefits and services provided by CHRISTUS Health Plan and contained in my "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CHRISTUS Health Plan will pay for benefits or services that are not covered. I will abide by the rules of my Evidence of Coverage. Once I am a member of CHRISTUS Health Plan, I have the right to appeal plan decisions about payment or services if I disagree.
This CHRISTUS Health Plan serves a specific service area. If I move out of the area that my selected plan serves, I need to notify CHRISTUS Health Plan so I can disenroll and find a new plan in my new area. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
Once CHRISTUS Health Plan has received my enrollment form, I may get a verification letter to make sure that I understand how my plan works and to confirm my intent to enroll. This is not a secondary plan to Medicare Parts A and B. CHRISTUS Health Plan pays instead of Medicare, and I will be responsible for the amounts that CHRISTUS Health Plan doesn't cover, such as copayments and coinsurances. Medicare Parts A and B won't pay for my healthcare while I am enrolled in CHRISTUS Health Plan.
CHRISTUS Health Medicare Complete (HMO) pays instead of Medicare, and I will be responsible for the amounts that CHRISTUS Health Medicare Complete (HMO) doesn't cover, such as copayments and coinsurances. Original Medicare won't pay for my health care while I am enrolled in CHRISTUS Health Medicare Complete (HMO).

Continues on next page

Applicant name: _____

Applicant Medicare number: _____

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Agreements continue from previous page.

Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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.
If you are requesting membership in a Chronic Condition Special Needs Plan (C-SNP), the following statement applies: I understand this plan is a chronic condition special needs plan. My ability to enroll is based on physician verification that I have the qualifying medical condition(s).
I understand that I am enrolling into a CHRISTUS Health Plan Medicare Advantage plan and not a Medicare Supplement, Medigap, Medicare Select or Medicaid plan.
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.
To cancel my plan, I can call the plan prior to the effective date; additional information is provided in the plan's enrollment letter, which I'll be receiving soon.
You can file a complaint if you have concerns about the quality of care or other services you get from a Medicare provider or about your Medicare plan. How you file a complaint depends on what your complaint is about. For help filing a complaint, visit Medicare.gov, call 1.800.MEDICARE (24 hours a day/7 days a week), or contact your local State Health Insurance Assistance Program (SHIP) for free personalized help.

☐ I acknowledge that I have read the above information and understand the contents of the application.

Applicant name: _____

Applicant Medicare number: _____

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Release of Information: By joining this Medicare health plan, I acknowledge that CHRISTUS 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 provided false information on this form, I will be disenrolled from the plan.

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.

2. Documentation of this authority is available upon request from Medicare.

SIGNATURE OF APPLICANT* or authorized legal representative (including power of attorney, legal guardian, etc.)

_____

Signature date (MM/DD/YYYY) _____

If you are the authorized legal representative, you **MUST** sign above and provide the following information:

Last name	First name	Middle initial
_____	_____	_____

Street address

_____

City	State	Zip code
_____	_____	_____

Telephone number	Relationship to applicant
_____	_____

Applicant name: _____

Applicant Medicare number: _____

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

What is your gender? Select one.

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

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

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

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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): _____

[optional space for other administrative information needed by plan]

Agent use only

Writing agent name:

_____
Print name: (required)

Writing agent signature:

_____
Signature (required)

Plan ID #: _____ Broker NPN #: _____

Effective date of coverage: _____

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

Where did this application originate?

☐ Clinic ☐ In-home appointment ☐ Event ☐ Office ☐ Other

Applicant name: _____

Applicant Medicare number: _____

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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.
- ☐ 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):
- ☐ 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 received 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 both Medicare and Medicaid (or my state helps me pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home). I moved | will move into | out of the facility on (insert date):
- ☐ I recently left a PACE program on (insert date):
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date):
- ☐ I am leaving employer or union coverage on (insert date):
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date):

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☐ I was enrolled in a Special Needs Program (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date):

If none of these statements applies to you or you are not sure, please contact CHRISTUS Health Plan at **844.282.3026**, or **711** for TTY users, to see if you are eligible to enroll, Monday through Friday, 8 a.m. to 8 p.m., local time.