SECTION 1 (continued): To enroll, all fields in this section are required (unless marked optional)

Applicant Contact Information:

Permanent Residence Address (P.O. Box not allowed)

Street _____

City _____ State _____ Zip _____

Phone (_____) _____ Email* _____

Mailing Address, if different from permanent address

Attn Name _____

Street _____

City _____ State _____ Zip _____

Responsible Party Contact Information (as applicable):
If you're the authorized representative, you must sign previous page and fill out these fields:

First Name _____ Last Name _____

Relationship to Enrollee _____

Phone ☐ Cell** ☐ Home (_____) _____

Email* (optional) _____

* *By providing your email address, you are opting in to receive electronic communication, when available. If you'd like to opt out of electronic communications, check this box:* ☐ *Opt out*

** *By providing your cell phone number, you are opting in to receive plan communications via SMS/text message. If you do not wish to receive any plan communications or updates via text message, please opt out:* ☐ *Opt out*

CONTINUED >>

SECTION 2: All fields are optional. Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

1. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

   IF YES, what is your Medicaid number? _____

2. Do you work? ☐ Yes ☐ No
   Does your spouse work? ☐ Yes ☐ No

3. Please choose your in-network Primary Care Physician (PCP):

   Physician Name: _____

   Is this your current physician? ☐ Yes ☐ No

4. 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
   ☐ Audio File
   ☐ Large Print
   ☐ Braille

   Please contact Align Senior Care at 1-855-855-0489 (TTY 711) if you need information in an accessible format or language other than what is listed above. Our office hours are 8:00 am to 8:00 pm local time. TTY users can call (TTY 711).

CONTINUED >>

SECTION 2 (continued): All fields are optional. Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Paying Your Plan Premium

For plans with a premium, you can pay your monthly plan 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.**

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. 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 Align Senior Care 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) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

OFFICE USE ONLY. Please DO NOT complete unless authorized.

Agent First and Last Name _____

Plan ID _____

Application received date _____ Coverage effective date _____

Select the enrollment period:

☐ IEP/ICEP

☐ AEP

☐ OEPI

☐ SEP (type) _____

☐ Not eligible

Signature _____ Date _____