☐ Male ☐

☐ Mr. ☐ Mrs. ☐

Align Senior Care? ☐ Yes ☐

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

CONTINUED >>

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

2. Are you a resident of or expect to be a resident of a long-term care facility (LTC) or an assisted living facility (ALF) in the Align Senior Care network for more than 90 days?

☐ Yes ☐ No

IF YES, please fill out the facility information below:

Name of Facility _____

Street Address _____

City _____ State _____ Zip _____

Phone Number of Facility _____

3. Who helped you complete this application?

☐ Agent NPN#_____ ☐ SHIP Counselor ☐ Other (Third Party)

☐ Broker ☐ Authorized Representative ☐ Self

CONTINUED >>

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

IMPORTANT: Read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Align Senior Care.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Align Senior Care 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).
- 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 are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Align Senior Care coverage begins, I must get all of my medical and prescription drug benefits from Align Senior Care. Benefits and services provided by Align Senior Care and contained in my Align Senior Care "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Align Senior Care will pay for benefits or services that are not covered.
- 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 of applicant or the responsible party X	Today's Date

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 (_____) _____ Cell Phone** (_____) _____

Email* (optional)_____

Mailing Address, if different from permanent address (P. O. Box allowed)

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 _____

Street _____

City _____ State _____ Zip _____

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 ☐ Large Print ☐ Compact Disc (CD)
   ☐ Audio File ☐ Braille ☐ None of the above

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

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

6. What's your race? Select all that apply.

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

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.

7. What is your gender? Select one.

☐ Woman ☐ Non-binary ☐ I choose not to answer

☐ Man ☐ I use a different term ☐ I don't know

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

☐ Lesbian or gay ☐ Bisexual ☐ I choose not to answer

☐ Straight, that is, not gay or lesbian ☐ I use a different term ☐ I don't know

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.**

- ☐ Yes, I'd like my premium to be taken out of my Social Security
- ☐ Yes, I'd like my premium to be taken out of my Railroad Retirement Board (RRB)
- ☐ No, none of the above. I would like a direct bill
- ☐ Not applicable

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) 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. 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 _____