Geisinger
HEALTH PLAN

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

# Geisinger Gold Medicare Advantage enrollment request

## Who can use this form?

People with Medicare who want to join a Medicare Advantage 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 Oct. 15 and Dec. 7 each year (for coverage starting Jan. 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 number (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 (Oct. 15 – Dec. 7), the plan must get your completed form by Dec. 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:

Geisinger Gold
100 N. Academy Ave.
Danville, PA 17822-3227

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

## How do I get help with this form?

Call Geisinger Gold at 800-483-2598. TTY users can call 711. Our office hours are 8 a.m. to 8 p.m., 7 days a week from Oct. 15 through Dec. 7; or 8 a.m. to 8 p.m. Monday through Friday from Dec. 8 through Oct. 14. Or call Medicare at 800-MEDICARE (800-633-4227). TTY users can call 877-486-2048.

**En español:** Llame a Geisinger Gold al 1-800-483-2598 / 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en 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 of a shelter or clinic, or the address where you receive mail (e.g., Social Security checks) may be considered your permanent residence address.

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**Office Use Only** Application: Left with applicant __ Mail __ Office __ Meeting _

Effective Date of Coverage:_____ICEP/IEP: ___ AEP: ____ SEP (type): ___

Agent/Producer Signature

Agent/Producer Printed

Name Agent/Producer ID

Number Agency Name

## Section 1 – You must complete all the questions in this section.

**Select the plan you want to join:**

- ☐ Heritage (HMO) $___ per month
- ☐ Classic Advantage Rx (HMO) $___ per month
- ☐ Classic Complete Rx (HMO) $____ per month
- ☐ Classic Essential Rx (HMO) $___ per month
- ☐ Classic 360 Rx (HMO) $___ per month
- ☐ Value Rx (HMO) $___ per month
- ☐ Secure Rx (HMO D-SNP) $___ per month
- ☐ Preferred Advantage Rx (PPO) $___ per month
- ☐ Preferred Advantage Rx (PPO) with Health+ $___ per month
- ☐ Preferred Complete Rx (PPO) $___ per month
- ☐ Preferred Complete Rx (PPO) with Health+ $___ per month
- ☐ Preferred Enhanced Rx (PPO) $___ per month

| First name: | Last name: | | Middle initial (optional): |
|---|---|---|---|
| Birth date (MM/DD/YYYY):<br>(  /  /  ) | Sex:<br>☐ Male | ☐ Female | Phone number:<br>(  ) |

**Permanent resident street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address):**

| City: | County: | State: | ZIP code: |
|---|---|---|---|

**Mailing street address, if different from your permanent address (P.O. box allowed):**

| City: | County: | State: | ZIP code: |
|---|---|---|---|

## Your Medicare information

Medicare number: _ _ _ - _ _ _ - _ _ _ _

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## Answer these important questions

Some individuals may have other medical or drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits or state pharmaceutical assistance programs.

**Will you have other medical coverage in addition to Geisinger Gold?** ☐ Yes ☐ No

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

| **Name of other coverage:** | **ID # for this coverage:** | **Group # for this coverage:** |
|---|---|---|
| | | |

**Will you have other prescription drug coverage in addition to Geisinger Gold?** ☐ Yes ☐ No

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

| **Name of other coverage:** | **ID # for this coverage:** | **Group # for this coverage:** |
|---|---|---|
| | | |

## Answer these important questions

**Are you a resident in a long-term care facility, such as a nursing home?** ☐ Yes ☐ No

If "yes," please provide the following information:

| **Institution address:** | **Institution phone number:** |
|---|---|
| | |

**HMO plans: List your primary care physician (PCP), clinic or health center.**

| **Office location:** | **PCP #:** |
|---|---|
| | |

## Important: Read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Geisinger Gold.
- By joining this Medicare Advantage Plan, I acknowledge that Geisinger Gold 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 Geisinger Gold coverage begins, I must get all of my medical and prescription drug benefits from Geisinger Gold. Benefits and services provided by Geisinger Gold and contained in my Geisinger Gold "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Geisinger Gold will pay for benefits or services that are not covered.

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- 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**

| Address | Phone Number | Relationship to Enrollee |
|---|---|---|
| | | |

## Paying your plan premiums

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 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 Medica (or the RRB). DON'T pay Geisinger Gold 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.

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## Attestation of eligibility for an enrollment period

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between Oct. 15 and Dec. 7 of each year. This coverage is effective on the first day of the following 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.

- ☐ Annual Enrollment Period (Oct. 15 – Dec. 7)
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I am new to Medicare.
- ☐ 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 got 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 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 or long-term care facility). I moved/will move into/out of the facility on (insert date): _____.
- ☐ I recently left a Program of All-Inclusive Care for the Elderly (PACE) 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): _____.
- ☐ I was enrolled in a Special Needs Plan (D-SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the D-SNP on (insert date):_____ .
- ☐ I am eligible for Medicare due to disability.
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.
- ☐ None of these statements applies to me. Contact Geisinger Gold at 800-514-0138 (TTY users should call 711) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., 7 days a week (Oct. 15 – Dec. 7); or 8 a.m. to 8 p.m., Monday through Friday (Dec. 8 - Oct. 14).

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## Section 2 – All fields on this page are optional

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

**Let us know if you want us to send you information in a language other than English.**

- ☐ English
- ☐ Spanish
- ☐ Nepali
- ☐ Chinese
- ☐ Arabic
- ☐ Russian
- ☐ Hindi
- ☐ Gujarati
- ☐ Other: _____

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

| | | | |
|---|---|---|---|
| ☐ Large print | ☐ Audio CD | ☐ Braille | ☐ Data CD |

Please contact Geisinger Gold at 800-498-9731 (TTY users should call 711) if you need information in an accessible format other than what's listed above. Our office hours are seven days a week from 8 a.m. – 8 p.m. from Oct. 1 – March 31; all other dates are Monday through Friday, 8 a.m. – 8 p.m. and Saturday, 8 a.m. – 2 p.m.

The information below may be used to identify possible application, enrollment and coverage barriers, and disparities for the communities we serve so we can work toward improving services for all members. It does not impact plan options, health insurance cost or eligibility. Consumer-reported race and ethnicity information is protected from disclosure or unauthorized access.

**Do you require interpreter services for a spoken language or sign language?** ☐ Yes ☐ No

**Race:**
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African or American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Decline to provide

**Ethnicity:**
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to provide

**Gender identity:**
- ☐ Male
- ☐ Female
- ☐ Transgender male (female-to-male)
- ☐ Transgender female (male-to-female)
- ☐ Choose not to disclose
- ☐ Other*

**Sex assigned at birth:**
- ☐ Male
- ☐ Female
- ☐ Not recorded on birth certificate
- ☐ Uncertain
- ☐ Choose not to disclose

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## Section 2 continued – All fields on this page are optional

**Sexual orientation:**

- ☐ Straight (not lesbian or gay)
- ☐ Lesbian or gay
- ☐ Bisexual
- ☐ Something else*
- ☐ Don't know
- ☐ Choose not to disclose

**Pronouns:**

- ☐ She/her/hers
- ☐ He/him/his
- ☐ They/them/theirs
- ☐ My name
- ☐ Not listed*

**Veteran status:**

- ☐ Veteran
- ☐ Currently serving
- ☐ Never served (not a veteran)
- ☐ Something else*
- ☐ Choose not to disclose

**Branch of service:**

- ☐ Air Force
- ☐ Air National Guard
- ☐ Air Force Reserve
- ☐ Army
- ☐ Army National Guard
- ☐ Army Reserve
- ☐ Coast Guard
- ☐ Coast Guard Reserve
- ☐ Marine Corps
- ☐ Marine Corps Reserve
- ☐ Navy
- ☐ Navy Reserve
- ☐ Multiple branches

**Years of Service:** _____