Geisinger Gold Medicare Advantage Enrollment Request

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 January1)
- 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 (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:
Geisinger Gold
100 North Academy Avenue
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 October 15 through December 7; or 8 a.m. to 8 p.m., Monday through Friday from December 8 through October 14. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). You may call 24 hours a day, 7 days a week. You may call 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.
En español: Llame a Geisinger Gold al (800) 483-2598 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.

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

☐ 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

☐ Preferred 360 Rx (PPO) $___ per month

☐ First Name: _____

☐ LAST Name: _____

☐ Middle Initial (Optional): ___

☐ Birth Date (M M / D D / Y Y Y Y):

_ _/_ _/_ _ _ _

Sex: ☐ M ☐ F

☐ Home Phone Number:

(_ _ _) _ _ _ - _ _ _ _

☐ E-mail Address (optional):

_____

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

_____

City: _____ State: _____

ZIP Code: _____ County: _____

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

_____

City: _____ State: _____

ZIP Code: _____

Your Medicare information:

Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _

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
_____	_____	_____

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

If "yes," please provide the following information: Name of Institution: _____

Address & Phone Number of Institution): _____

HMO plans: List your Primary Care Physician (PCP), clinic, or health center:

Doctor Name and 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 or Medicare Prescription Drug 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).
- 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.

- 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:

Name:

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 Medicare (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.

Attestation of eligibility for an enrollment period

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between October 15 and December 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 (October 15 through December 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 (October 15 - December 7); or 8 a.m. to 8 p.m., Monday through Friday (December 8 - October 14).

Section 2 – Answering these questions is optional.

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

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

Language:

- ☐ English
- ☐ Spanish
- ☐ Nepali
- ☐ Chinese
- ☐ Arabic
- ☐ Russian
- ☐ Hindi
- ☐ Gujarati

Other: _____

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

Braille Large print Audio 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 – Mar. 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 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

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)
- ☐ 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: _____