OMB No. 0938-1378
Expires: 12/31/2026

MODEL INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

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 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:
Verda Health Plan of Arizona
Attn: Enrollment Dept.
P.O. Box 105213
Jefferson City, MO 65110

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

How do I get help with this form?

Call Verda Health Plan of Arizona at 1-877-933-6767 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 Verda Health Plan de Salud Arizona al 1-877-933-6767/TTY o a Medicare gratis al 1-800-633-4227 y oprima el 8 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.

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 0938-1378. 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.

VERDA
HEALTH PLAN OF ARIZONA

P.O. Box 105213
Jefferson City, MO 65110
Enrollment FAX: (714) 845-9841

Section 1 – All fields on this page are mandatory (unless marked as optional)

Choose the plan you want to enroll in:

☐ Verda Noble Care Plan (HMO) – 001
$0, per month
Maricopa County

☐ Verda Noble Chronic Care Plan (HMO C-SNP)-002
$0, per month
Maricopa County

First Name: Last Name: Middle Initial:

Date of birth: (MM/DD/YYYY)
(__ __ /__ __ / ___ ___ ___ __)

Sex:
☐ M ☐ F

Phone Number:
( )

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

City: State: Zip code: County:

Mailing address, if different from your permanent address (PO Box allowed):

City: State: Zip code:

Your Medicare Information

Please take your Red, White and Blue Medicare card to complete this section.

•Fill this information as it appears on your Medicare card.

-OR-

•Attached 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: __ __ __ __- __ __ __- __ __ __ __

HOSPITAL (Part A): __ __ / __ __ / __ __ __ __

MEDICAL (Part B): __ __ / __ __ / __ __ __ __

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

Answer these important questions:

1. Will you have other prescription drug coverage (such as VA, TRICARE) in addition to Verda Health Plan of Arizona? ☐ Yes ☐ No

Name of other coverage: Member number for this coverage: Group number for this coverage:

_____ _____ _____

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

If "yes", please provide the following information: Medicaid ID #: _____

3. Do you have Cardiovascular Disorder, Congestive Heart Failure (CHF) and or Diabetes? ☐ Yes ☐ No
*If yes, please fill out the Pre-Enrollment Qualification Assessment form found towards the end of this booklet.

Important: Read and Sign Below:
•I must keep both Hospital (Part A) and Medical (Part B) to stay in Verda Health Plan of Arizona. •By joining this Medicare Advantage [or Medicare Prescription Drug] Plan, I acknowledge that Verda Health Plan of Arizona 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 Verda Health Plan of Arizona coverage begins, I must get all of my medical and prescription drug benefits from Verda Health Plan of Arizona. Benefits and services provided by Verda Health Plan of Arizona and contained in my Verda Health Plan of Arizona "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Verda Health Plan of Arizona 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 are the authorized representative, sign above and fill out these fields: Name: _____Address: _____ Phone Number: _____ Relationship to enrollee: _____
Section 2 – All fields on this page are optional
Answering these questions is your choice. You cannot be denied coverage because you don't fill them out.
Select one if you want us to send you information in a language other than English. ☐ Spanish
Select an option below if you want us to send you information in an accessible format: ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD Please contact Verda Health Plan of Arizona at 1-888-256-5123 (TTY users should call 711) if you need information in an accessible format or language other than what is listed above. Our office hours are from 8 a.m. – 8 p.m.,7 days a week from October 1 to March 31 and from 8 a.m. – 8 p.m. Monday thru Friday April 1 to Sept 30
Do you work? ☐ Yes ☐ No / Does your spouse work? ☐ Yes ☐ No
Please choose a Primary Care Physician (PCP)*: _____ **PCP IPA/Medical Group Name:** _____ **PCP ID #:** _____ **Are you an existing patient?** ☐ Yes ☐ No
I want to get the following materials via email. Select one or more. ☐ Evidence of Coverage ☐ ANOC

Email address: _____

Paying your Plan Premiums

You can pay your monthly premiums (including any late enrollment penalties you currently have or own) by mail every 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 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 my monthly benefits from: ☐ Social Security ☐ RRD

The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

If you must pay a Part D Income Related Monthly Adjustment Amount (IRMAA), you must pay this additional amount in addition to your plan premium. Usually, the amount is deducted from your Social Security benefit, or you may receive a bill from Medicare (or the RRB). DO NOT pay the Part D IRMAA to **Verda Health Plan of Arizona**.

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.

☐ IEP/ICEP ☐ AEP ☐ OEP ☐ SEP (type) _____

Name: _____ Relationship to enrollee: _____

Signature: _____ National Producer Number (Agents/Brokers only): _____

Application Receive Date: _____

Proposed Effective Date: _____(Required)

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 and 1860D-1 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 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 Annual Enrollment Period (AEP), 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 recently moved outside of the service area for my current plan, or I recently moved, and have new options available to 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 Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).

☐ 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 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'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.

☐ 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 (SNP), but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

☐ I have a Chronic Condition that qualifies me for the chronic condition Special Needs Plan. (C-SNP Only)

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact Verda Health Plan of Arizona at

1-877-933-6767, TTY users should call 711 to see if you are eligible to enroll. Our office hours are from 8 a.m. – 8 p.m., 7 days a week from October 1st to March 31st and from 8 a.m.-8 p.m. Monday through Friday from April 1 to September 30

VERDA
HEALTH PLAN OF ARIZONA

Coordination of Care Form (Required for Both Plans)

Coordination of Care Form

Member Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Date of Birth: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Preferred Spoken Language:

☐ English ☐ Spanish ☐ Cantonese ☐ Korean ☐ Mandarin ☐ Tagalog ☐ Vietnamese ☐ Other: _____

Primary Care Physician / Medical Group Information

PCP with Verda Health Plan of Arizona: _____

	YES	NO **
Is this the same PCP as prior to enrolling with Verda?	☐	☐

Medical Group / IPA with Verda Health Plan of Arizona: _____

	YES	NO **
Is this the same Medical Group / IPA as prior to enrolling with Verda?	☐	☐

** If NO, who is the current PCP and/or Medical Group/IPA? _____

Continuity Of Care and Services

Please inform us if you have any of the following issues that apply to you, and we will have a Care Coordination Team member contact you to assist with the transition of services.

☐ Immediate Needs – Food, housing, medication affordability, etc.
☐ Currently Hospitalized
☐ Middle of Treatment – Chemotherapy / Dialysis / Home Health, etc.
☐ Planned Surgery in the coming months
☐ Durable Medical Equipment – ☐ Own ☐ Rent **
☐ Continuous Glucose Monitors (such as Dexcom or FreeStyle Libre)
☐ CPAP Machine ☐ Oxygen ☐ Hospital Bed
☐ Diapers ☐ Pressure Mattress ☐ Catheters

** If you rent DME, who is the DME Company? Name: _____ Phone: _____

Medications

Please provide a list of medications that require Prior Authorization or are not on our formulary. A Care Coordination Team member will contact you to assist with the prescription transition fills.

Medication Name: _____ Dosage: _____
Medication Name _____ Dosage: _____
Medication Name _____ Dosage: _____

VERDA
HEALTH PLAN OF ARIZONA

Pre-Enrollment Qualification Assessment Form

PLEASE READ (Required for C-SNP Only): To enroll in the Verda Health Plan of Arizona Chronic Condition Special Needs Plan, we are required to confirm your diagnosis of a qualifying health condition. When this form is completed and submitted along with an enrollment application, you will be enrolled in the Verda Health Plan of Arizona C-SNP Plan. We will attempt to verify your chronic condition(s) with your provider during the first month of enrollment. If we are unable to verify your chronic condition(s), we are required to disenroll you from our Special Needs Plan.

Your Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Gender: ☐ Male ☐ Female DOB: _____

Chronic Condition Questions:

If any of the following are checked, the enrollee pre-qualifies.
Have you ever been told by a physician that you have any of the following conditions:

- ☐ Diabetes Mellitus (High blood sugar)
- ☐ Chronic Heart Failure (CHF, fluid in the lungs)
- ☐ Cardiovascular Disorders – must be one of the following:
  - Cardiac Arrhythmias (heart rhythm problem)
  - Coronary Artery Disease (blocked arteries of the heart, stents in the heart)
  - Peripheral Vascular Disease (blocked arteries of the legs)
  - Chronic Venous Thromboembolic Disorder (blood clots in the legs or lungs)

Additional Questions

1. Do you take any medications for the conditions listed above? ☐ Yes ☐ No
2. Are you now or have you ever taken Metformin or Insulin Injection? ☐ Yes ☐ No

Please check all medications below that you currently take or have previously taken:

☐ Metformin	☐ Janumet	☐ Insulin	☐ Lantus	☐ Lasix/Furosemide	☐ Plavix
☐ Glyburide	☐ Jardiance	☐ Humulin	☐ Levemir	☐ Bumex	☐ Xarelto
☐ Glipizide	☐ Tradienta	☐ Novolin	☐ Tresiba	☐ Aldactone	☐ Eliquis
☐ Actos	☐ Trijardy	☐ Novolog	☐ Ozempic	☐ Digoxin	☐ Coumadin
☐ Avandia	☐ Invokana	☐ Humalog	☐ Mounjaro	☐ Amiodarone	☐ Nitroglycerin
☐ Farxiga	☐ Invokamet	☐ Toujeo	☐ Trulicity	☐ Rhythmol	☐ Ranexa

Others:

☐	☐	☐
☐	☐	☐
☐	☐	☐

REQUIRED Current Treating Physician

Provider Name: _____ Address: _____

Phone Number: _____ Fax Number: _____

** REQUIRED** Current Specialist (If none, write N/A)

Specialist Name: _____ Address: _____

Phone Number: _____ Fax Number: _____

Disclaimer and Signature

Authorization for Disclosure of Health Information to verify Chronic Condition(s):

I hereby authorize the disclosure of my health information by the provider(s) listed above to Verda Health Plan to verify that I have been diagnosed with a chronic condition which qualifies me for enrollment in a Verda Special Needs Plan. This authorization applies to all health information maintained by the provider concerning my medical history for the chronic condition(s) indicated above.

Note: *Information disclosed because of this authorization will be protected by Verda Health Plan in accordance with applicable state and federal laws and requirements.*

Enrollee Signature: _____ Date: _____