# Enrollment Form

Lagniappe ADVANTAGE

**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 January 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 (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 monthly Social Security (or Railroad Retirement Board) benefit.

**What happens next?**
Send your completed and signed form to:
Lagniappe Advantage
P.O. Box 1030
Glen Burnie, MD 21060-1030
Once they process your request to join, they'll contact you.

**How do I get help with this form?**
Call Lagniappe Advantage at 1-844-217-0052 (TTY 711).

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

*En español:* Llame a Lagniappe Advantage al 1-844-217-0052 (TTY 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.

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.**


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

**Please check which plan you want to enroll in:**

☐ Lagniappe Advantage (PPO I-SNP) - $32.90 per month

If you get Extra Help from Medicare, your monthly plan premium will be lower than what it would be if you didn't get Extra Help from Medicare. Depending on your level of Extra Help, your premium may be anywhere between $0 and $32.90. **If you are full-dual eligible, with Extra Help, your premium would be $0.**

**Applicant Information:** ☐ Male ☐ Female

☐ Mr. ☐ Mrs. ☐ Ms. Birth Date (MM/DD/YYYY): (_____/_____/_____)

First Name _____ Last Name _____ M.I. ___

Medicare Number (MBI)_____

1. Will you have other prescription drug coverage in addition to Lagniappe Advantage? ☐ Yes ☐ No

   **IF YES**, please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other drug coverage _____

   Member number for this coverage _____

   Group number for this coverage _____

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

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**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 Lagniappe Advantage 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

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**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 Lagniappe Advantage.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Lagniappe Advantage 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 Lagniappe Advantage coverage begins, I must get all of my medical and prescription drug benefits from Lagniappe Advantage. Benefits and services provided by Lagniappe Advantage and contained in my Lagniappe Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Lagniappe Advantage 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 | Today's Date |
|---|---|
| X | |


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**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*

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**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

**Please contact Lagniappe Advantage at 1-844-217-0052 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.**

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**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 Lagniappe Advantage 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 _____


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