



# 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 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 January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit [Medicare.gov](https://www.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:

Tribute Health Plans  
P.O. Box 3630  
Little Rock, AR 72202

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

## How do I get help with this form?

Call Tribute Health Plans at 877-372-1033. 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 Planes de salud tributo al 877-372-1033/711 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.**



**Tribute Health Plans**  
PO Box 3630  
Little Rock, AR 72202  
Fax #: (866) 819-4774  
TributeMedicare.com

Section 1-All fields on this page are required (unless marked optional)			
<b>Select the plan you want to join:</b>			
<input type="checkbox"/> Tribute Advantage (HMO-POS D-SNP) \$0 per month		<input type="checkbox"/> Tribute Select (HMO-POS I-SNP) \$0-26.10 per month depending on your level of assistance.	
FIRST Name:		LAST Name:	Middle Initial:
Birth Date: (MM/DD/YYYY) (__/__/____)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone Number: ( )	
Permanent Residence Street address (Don't enter a PO Box):			
City:	County:	State:	ZIP Code:
Mailing address, if different from your permanent address (PO Box allowed):			
Street Address:		City:	State: ZIP Code:
Your Medicare information			
<b>Medicare Number:</b>	_____ - _____ - _____		
Answer these important questions:			
Will you have other prescription drug coverage (like VA, TRICARE) in addition to Tribute? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of other coverage:	Member number for this coverage:	Group number for this coverage:	
_____	_____	_____	
To be completed for DSNP Enrollment:			
Are you enrolled in your State Medicaid program? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide your Medicaid number: _____			
Do you reside in a long-term care facility, such as a nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Facility: _____			
<input type="checkbox"/> I reside in my home and require institutional level of care			
IMPORTANT: Read and sign below:			
<ul style="list-style-type: none"><li>• I must keep both Hospital (Part A) and Medical (Part B) to stay in Tribute.</li><li>• By joining this Medicare Advantage Plan, I acknowledge that Tribute 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).</li></ul>			

- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- 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 Tribute coverage begins, I must get all of my medical and prescription drug benefits from Tribute. Benefits and services provided by Tribute and contained in my Tribute “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Tribute 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:**

**Today’s date:**

If you’re 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 can’t be denied coverage because you don’t fill them out.**

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

- |   |  |
|---|--|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin   | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican                                  | <input type="checkbox"/> Yes, Cuban                                |
| <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> <b>I choose not to answer.</b>            |

What’s your race? Select all that apply.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Asian American         | <input type="checkbox"/> Black or African American |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Filipino               | <input type="checkbox"/> Guamanian or Chamorro     |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Korean                 | <input type="checkbox"/> Native Hawaiian           |
| <input type="checkbox"/> Other Asian                      | <input type="checkbox"/> Other Pacific Islander | <input type="checkbox"/> Samoan                    |
| <input type="checkbox"/> Vietnamese                       | <input type="checkbox"/> White                  |  |
| <input type="checkbox"/> <b>I choose not to answer.</b>   |   |  |

Select one if you want us to send you information in a language other than English.

Español

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

Braille  Large print  Audio CD

Please contact Tribute Health at 877-372-1033 if you need information in an accessible format other than what's listed above. Our office hours are 8:00 a.m. to 8:00 p.m. 7 days a week. TTY users can call 711.

Do you work?  Yes  No Does your spouse work?  Yes  No

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

I want to get the following materials via email. Select one or more.

Evidence of Coverage  a list of providers (Provider Directory)  
 a list of pharmacies (Pharmacy Directory)  a list of covered drugs (Formulary)

Email address:

### 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 each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check 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.

**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 Tribute Health Plans the Part D-IRMAA.

### Office Use Only

Application Received Date:

Application System Entry Date:

Effective Date of Coverage:

Plan ID #:

Election Period:

Agent/Broker:

**PRIVACY ACT STATEMENT**

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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