



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 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:
Brandman Health Plan
P.O. Box 17960
Encino, CA 91416

Email: enrollment@brandmanhealthplan.com

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

How do I get help with this form?

Call Brandman Health Plan at 1-888-697-5662. 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 Brandman Health Plan al 1-888-697-5662/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.

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

Select the plan you want to join:

Brandman Health Plan Aspire (HMO C-SNP) 003 – \$0 per month

Brandman Health Plan Aspire-D (HMO C-SNP) 004 - \$31.50 per month

FIRST name:

LAST name:

Middle Initial:

Birth date:

Sex: Male Female

Phone number:

(MM/DD/YYYY)

()

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:

Medicare/Medi-Cal

Medicare Number:

----- - ---- - ----

Medi-Cal Number:

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Brandman Health Plan (HMO C-SNP)? Yes No Name of other coverage: _____

Member number for this coverage: _____ Group number for this coverage _____

Please list your current medications:

Have you been diagnosed with one or more of the following conditions?

Dementia Alzheimer's Any cognitive memory issues

Do you use any assistive devices?

None Shower chair Raised toilet seat
 Cane Wheelchair Walker Other: _____

Name of your current DME company: _____ N/A

Please list any other immediate health concerns you may have:

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Brandman Health Plan
- By joining this Medicare Advantage Plan, I acknowledge that Brandman Health Plan 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.
- 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 Brandman Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Brandman Health Plan. Benefits and services provided by Brandman Health Plan and contained in my Brandman Health Plan “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Brandman Health Plan 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 in this next section are optional

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

Select one if you want us to send you information in an accessible format.
 Braille Large print Audio CD

What is your preferred language:
 English Spanish Other _____

Please contact Brandman Health Plan at 1-888-697-5662 if you need information in an accessible format other than what’s listed above. Our office hours are October 1 – March 31: Seven days a week, from 8:00 a.m. to 8:00 p.m. or April 1 – September 30: Monday through Friday, from 8:00 a.m. to 8:00 p.m. 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.
 Information about plan benefits Provider/Pharmacy Directories All plan communications

E-mail address: _____

Agent use only

Agent Name:	Date:
-------------	-------

FMO Name:	Enrollment effective date:
-----------	----------------------------

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.

Brandman Health Plan is a HMO C-SNP with a Medicare contract. Enrollment in Brandman Health Plan (HMO C-SNP) depends on contract renewal.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-697-5662 (TTY: 711).