BayCarePlus®
Medicare Advantage

OMB No. 0938-1378
Expires: 06/30/2026

2025 Enrollment Request Form

Use the form to enroll in BayCarePlus® Medicare 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 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 three months of first getting Medicare
- In certain situations in which you're allowed to join or switch plans

Go to 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 the Annual Enrollment Period (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a monthly invoice for the plan's premium and any applicable Late Enrollment Penalty and/or Optional Supplemental Benefit. 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:

BayCarePlus Medicare Advantage
P. O. Box 30764
Tampa, FL 33630

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

How do I get help with this form?
Call **BayCare**Plus Medicare Advantage at (877) 549-1741 (TTY: 711). Or call Medicare at 1-800-Medicare (1-800-633-4227). TTY users can call (877) 486-2048.

En español: Llame a **BayCare**Plus Medicare Advantage al (877) 549-1741 (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, write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT: Don't 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 won't be kept, reviewed or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Contact **BayCare**Plus Medicare Advantage Sales at (877) 549-1741 if you need help completing this form. TTY users can call the national relay service toll-free at 711.

Section 1: All fields on this page are required *(unless marked optional)*.

Select the plan you want to join:

- ❑ **BayCare**Plus **Complete** (HMO) – H2235-001 (Hillsborough, Pasco, Pinellas and Polk counties) $0 per month
- ❑ **BayCare**Plus **Rewards** (HMO) – H2235-002 (Hillsborough, Pasco, Pinellas and Polk counties) $0 per month
- ❑ **BayCare**Plus **Premier** (HMO) – H2235-003 (Hillsborough, Pasco, Pinellas and Polk counties) $49 per month

Optional Supplemental Benefits: Comprehensive Dental ❑ Yes ❑ No

You can add optional supplemental benefits (comprehensive dental services) for an additional monthly premium. The monthly premium for your supplemental benefits will be in addition to your monthly plan premium and/or Late Enrollment Penalty.

- ❑ **BayCare**Plus **Complete**: $49.60 per month
- ❑ **BayCare**Plus **Rewards**: $50.20 per month
- ❑ **BayCare**Plus **Premier**: $49.60 per month

First name:	Last name:	Middle initial (optional):
Birth date: (__ __ /__ __ /__ __ __ __) (MM/DD/YYYY)	Sex: ❑ Male ❑ Female	Phone (select primary phone number): ❑ Cell: ( ) ❑ Home: ( )
Permanent residence street address (don't enter a P.O. box):		County (optional):
City:	State:	Zip:
Mailing address, if different from your permanent address (P.O. box allowed):		
Street address:		
City:	State:	Zip:
Email address (optional):		

Your Medicare Information

Medicare number: ___ ___ ___ ___- ___ ___ ___ - ___ ___ ___ ___

Answer These Important Questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to **BayCare**Plus Medicare Advantage? ❑ Yes ❑ No If "yes," list your other coverage and your identification (ID) number(s) for this coverage.

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

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IMPORTANT: Read and Sign Below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in **BayCare**Plus Medicare Advantage.
- By joining this Medicare Advantage plan, I acknowledge that **BayCare**Plus Medicare 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). I also acknowledge that **BayCare**Plus Medicare Advantage will share my information with other plans to make payments and for other purposes allowed by federal law that authorize the collection of this information.
- 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 or Part D plan at a time, and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan.
- I understand that when my **BayCare**Plus coverage begins, I must get all of my medical and prescription drug benefits from **BayCare**Plus. Benefits and services provided by **BayCare**Plus and contained in my **BayCare**Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor **BayCare**Plus will pay for benefits or services that aren't 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'll 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

Optional Supplemental Benefits (OSB) Conditions of Enrollment: If you checked "Yes" to add OSB on page 1, read the information below. By completing this enrollment application:

- I agree to adding the OSB, which includes comprehensive dental for an additional monthly premium based on the plan that I enroll in: **BayCare**Plus **Rewards** for $50.20 per month, **BayCare**Plus **Complete** for $49.60 per month or **BayCare**Plus **Premier** for $49.60 per month. This amount is in addition to my Medicare premium, **BayCare**Plus plan premiums and any applicable Late Enrollment Penalty (LEP) that may apply.
- I understand the OSB is only available to members enrolled in a **BayCare**Plus plan and that disenrollment from a **BayCare**Plus plan will result in automatic disenrollment from the optional supplemental benefits.
- I understand that the Delta Dental plan will pay benefits for covered services provided by a nonparticipating provider. However, a nonparticipating provider may charge more than the maximum plan allowance payable under this Medicare Advantage plan and I'll be responsible for all cost-sharing charges.
- I understand that if I disenroll from the OSB, I won't be eligible to enroll again until the next **BayCare**Plus valid OSB enrollment period.
- I understand that if I fail to pay the monthly premium for the OSB, I'll lose the OSB but will remain enrolled in **BayCare**Plus.
- I understand I only have one dental option. The purchase of this plan replaces the base plan, which has an annual maximum of up to $3,000, depending on my plan.

Signature:		**Today's date:**
If you're the authorized representative, sign above and fill out these fields:		
Name:	Relationship to enrollee:	Phone: ( )
Address: City:		State: Zip:

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Section 2: All fields in this section are optional.

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

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

- ❑ No, not of Hispanic, Latino/a or Spanish origin
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, another Hispanic, Latino/a or Spanish origin
- ❑ **I choose not to answer.**

What's your race? Select all that apply.

- ❑ American Indian or Alaska Native
- Asian:
  - ❑ Asian Indian
  - ❑ Chinese
  - ❑ Filipino
  - ❑ Japanese
  - ❑ Korean
  - ❑ Vietnamese
  - ❑ Other Asian
- ❑ Black or African American
- Native Hawaiian and Pacific Islander:
  - ❑ Guamanian or Chamorro
  - ❑ Native Hawaiian
  - ❑ Samoan
  - ❑ Other Pacific Islander
- ❑ White
- ❑ **I choose not to answer.**

What is your gender? Select one.

- ❑ Woman
- ❑ Man
- ❑ Non-binary
- ❑ I use a different term: _______________
- ❑ **I choose not to answer.**

Which of the following best represents how you think of yourself? Select one.

- ❑ Lesbian or gay
- ❑ Straight (not gay or lesbian)
- ❑ Bisexual
- ❑ I use a different term: _______________
- ❑ I don't know
- ❑ **I choose not to answer.**

Select if your preferred spoken language is a language other than English. ❑ Spanish

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

Select one if you want us to send you information in an accessible format. ❑ Audio CD ❑ Braille ❑ Large print
Contact **BayCare**Plus Medicare Advantage at (877) 549-1741 (TTY: 711), seven days a week, 8am to 8pm* if you need information in an accessible format or language other than what's listed above, or if your preferred spoken language is a language other than the one listed above.

Employment Status

Do you work? ❑ Yes ❑ No

Does your spouse work? ❑ Yes ❑ No

List your BayCarePlus network primary care physician (PCP), clinic or health center:

Primary care physician (PCP):	PCP # from the Provider Directory:	Is this your current physician?
Dr. ________________________________ *(First name)* *(Last name)*	☐☐☐☐☐☐☐☐☐☐	❑ Yes ❑ No

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PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining BayCarePlus Medicare Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join BayCarePlus Medicare Advantage. Read the communications your employer or union sends you. If you have questions, go to their website or contact the office listed in their communications. If there isn't any information on who to contact, your benefits administrator or the office that answers questions about your coverage can help.

Paying Your Plan Premiums

Whether you're enrolled in a premium or non-premium plan, you may pay your plan premium and any applicable Late Enrollment Penalty and/or OSB that you have or may owe by electronic funds transfer (EFT) or check each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security (SSA) or Railroad Retirement Board (RRB) benefit check 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 the **BayCare**Plus Medicare Advantage Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75 percent or more of your drug costs, including monthly prescription drug premiums and coinsurance. Additionally, those who qualify won't be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call the Social Security Administration at 1-800-772-1213. TTY users should call (800) 325-0778.

You can also apply for Extra Help online at SocialSecurity.gov/PrescriptionHelp. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Please select a premium payment option:

❑ **Automatic deduction from your monthly Social Security (SSA) or Railroad Retirement Board (RRB) benefit check.**
I get monthly benefits from: ❑ SSA ❑ RRB

It can take up to 90 days to receive SSA/RRB withhold acceptance. SSA/RRB will begin deducting on the date of acceptance. Members will receive an invoice for any months prior to the withhold acceptance date by SSA/RRB, which will be their responsibility to pay. In limited circumstances, Medicare may not allow for the SSA/RRB deduction option and may instruct the plan to directly bill the member. If this occurs, you'll be notified in writing. If you select this payment option, you won't receive a monthly invoice.

❑ **Electronic funds transfer (EFT) from your bank account each month.**
If you choose to have the funds taken directly out of your checking account, this is referred to as electronic funds transfer (EFT). If you elect this method of payment, you'll receive a letter from the plan requesting a voided check be returned with the letter for account setup. Don't submit a voided check at the time of enrollment. Your EFT request will be processed within 60 business days of the receipt of a returned voided check and letter. Premiums are deducted from your bank account on the second day of the month for the current month's coverage. If you select this payment option, you won't receive a monthly invoice.

❑ **Direct Pay**
You'll receive a monthly invoice containing payment instructions.

For Individuals Helping an Enrollee Complete 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.	
Name:	**Relationship to enrollee:**
Signature:	**National producer number (agents/brokers only):**

Return completed application to:

BayCarePlus Medicare Advantage
P. O. Box 30764
Tampa, FL 33630

*Call (877) 549-1741 for more information, including free language translation services, regarding your BayCare Select Health Plans. TTY users can call the national relay service toll-free at 711. Our telephone lines are open seven days a week, 8am to 8pm. You may receive a messaging service on weekends from April 1 through September 30 and holidays. Please leave a message, and your call will be returned the next business day. BayCare Select Health Plans is an HMO plan with a Medicare contract. Enrollment in BayCare Select Health Plans depends on contract renewal. You must continue to pay your Medicare Part B premium.

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.

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Return completed application to:

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P.O. Box 30764
Tampa, FL 33630

FOR OFFICE USE ONLY	
Confirmation # *(quick entry or phone enroll)*:	**Application log #:**
Plan ID #:	**Effective date of coverage:**

Election periods: ❑ **ICEP (I)** ❑ **IEP (E)** ❑ **2nd IEP (F)** ❑ **AEP (A)** ❑ **OEP (M)** ❑ **OEPI (T)**

Special Election Periods *(must check all that apply)*:

SEP (S)
- ❑ SPAP
- ❑ Loss of SNP
- ❑ Retro Entitlement
- ❑ Involuntary Loss/Cred. Coverage
- ❑ Contract/Plan Non-Renewal
- ❑ Contract Violations
- ❑ Contract Term-Immediate
- ❑ Contract Term-MAO
- ❑ Contract Term-CMS
- ❑ CMS Sanction
- ❑ FEMA/Disaster
- ❑ Plan Placed in Receivership
- ❑ CMS Identified Consistent Poor Performing Plan
- ❑ Accessible Format Delay
- ❑ Inv. Dis.–Loss of Part B
- ❑ PACE Transition
- ❑ Cost Plan Non-Renewal
- ❑ Drop Medigap in Trial Period
- ❑ Additional Part D IEP Eligibility
- ❑ Part B General Enrollment
- ❑ Lawfully Present
- ❑ COVID-19 Disaster

SEP (V)
- ❑ Permanent Move

SEP (W)
- ❑ Gain or Loss of Employer Coverage

SEP (L) Allowed Once per Quarter
- ❑ Dual Eligible/Has Medicaid
- ❑ Has Non-Dual with LIS

SEP (U)
- ❑ Gain/Loss/Change in Dual Eligible Status
- ❑ Gain/Loss/Change of Medicaid
- ❑ Gain/Loss/Change in Non-Dual LIS

SEP (R)
- ❑ 5-Star SEP

SEP (Other)
- ❑ ____________________

Producer name:	**Producer NPN:**	**Application receipt date:**

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