OMB No. 0938-1378
Expires: 7/31/2023

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:

FirstMedicare Direct
Application Processing Center
3310 Fields South Drive
Champaign, IL 61822

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

How do I get help with this form?

Call FirstMedicare Direct at
(800) 481-0496 (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 FirstMedicare Direct al o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

FirstCarolinaCare Insurance Company's FirstMedicare Direct plans are HMO and PPO plans with a Medicare contract. Enrollment in a FirstMedicare Direct plan depends on contract renewal.

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.

FirstMedicare Direct

FIRSTCAROLINACARE INSURANCE COMPANY

2021 Medicare Advantage Prescription Drug Plan (MAPD) Individual Enrollment Form

Please contact FirstMedicare Direct if you need information in another language or format (Braille or Large Print).

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

Select the plan you want to join:

❑ $0 per month FirstMedicare Direct POS Standard (HMO-POS)
❑ $39 per month FirstMedicare Direct POS Plus (HMO-POS)
Dental Buy-up (Optional) ❑ yes ❑ no
If yes, select one of the following:
❑ Optional Dental Silver $26
❑ Optional Dental Gold $45

FIRST name: LAST name: Optional: Middle Initial:

Birth Date: (__ __ / __ __ / __ __ __ __) M M D D Y Y Y Y	Sex: ❑ Male ❑ Female	Phone Number: ( ) -

Permanent Residence street address (Don't enter a PO Box):

____

City: ____________________ Optional: County: ________ State: ________ ZIP Code: ________

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

Street Address: _____________City: ____________________ State: ______ ZIP Code: _________

Your Medicare information:

Medicare Number: ______________________________

Answer these important questions:

Will you have other prescription drug coverage in addition to FirstMedicare Direct?

❑ Yes ❑ No If "yes", please 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:
______________________	______________________	______________________

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in FirstMedicare Direct.
- By joining this FirstMedicare Direct Plan, I acknowledge that FirstMedicare Direct 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 FirstMedicare Direct coverage begins, I must get all of my medical and prescription drug benefits from FirstMedicare Direct. Benefits and services provided by FirstMedicare Direct and contained in my FirstMedicare Direct "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor FirstMedicare Direct 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: **X**	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:

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.
Select one 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. ❑ Braille ❑ Large print ❑ Audio CD Please contact FirstMedicare Direct at (800) 481-0496 (TTY 711) if you need information in an accessible format or language other than what is listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. Voicemail is used on holidays and weekends from April 1 to September 30.
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. ❑ Using your coverage ❑ Information and updates about your plan E-mail address: ______________________________
Paying your plan premiums You can pay your monthly plan premium by mail, "Electronic Funds Transfer (EFT)", or credit card 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.** **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 FirstMedicare Direct the Part D-IRMAA.
OFFICE USE ONLY: Plan Requested Effective Date: Mo. ________ /2021 Date Received: ______________ Name of staff member/agent/broker (if assisted in enrollment): ________________________ Agent NPN: ____________________________ ICEP/IEP ❑ AEP ❑ SEP ❑ (type): Notes:

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.