



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](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:

Doctors HealthCare Plans, Inc.
Attention: Enrollment Department
2020 Ponce de Leon Blvd., PH1
Coral Gables, FL 33134

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

HOW DO I GET HELP WITH THIS FORM?

Call Doctors HealthCare Plans, Inc. directly at (786) 460-3427 or toll free at (833) 342-7463. 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 Doctors HealthCare Plans, Inc. al (786) 460-3427 o al (833) 342-7463, 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 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-NEW. 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.

| |
|-------------------------|
| PROPOSED EFFECTIVE DATE |
| |

2023 ENROLLMENT REQUEST FORM

All fields on this page are required (unless marked optional).

SELECT THE PLAN YOU WANT TO JOIN

MIAMI-DADE PLANS

- | | |
|--|---|
| <input type="checkbox"/> DrMax (HMO-POS) | <input type="checkbox"/> DrPlus (HMO-POS D-SNP) |
| <input type="checkbox"/> DrExtraCare (HMO-POS C-SNP) | <input type="checkbox"/> DrValue (HMO-POS) |

BROWARD PLANS

- | | | |
|--|---|--|
| <input type="checkbox"/> DrMax-B (HMO-POS) | <input type="checkbox"/> DrPlus-B (HMO-POS D-SNP) | <input type="checkbox"/> DrValue-B (HMO-POS) |
|--|---|--|

SECTION 1 — ALL FIELDS ON THIS PAGE ARE REQUIRED (UNLESS MARKED OPTIONAL)

| | | |
|-----------|------------|---------------------------|
| LAST Name | FIRST Name | Middle Initial (optional) |
|-----------|------------|---------------------------|

| | | | |
|-------------------------|--|---------------------|-------------------|
| Birth Date (mm/dd/yyyy) | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Phone Number () | Cell Phone () |
|-------------------------|--|---------------------|-------------------|

| | |
|--|--------|
| Permanent Residence Street Address (Do not enter a PO Box) | Apt. # |
|--|--------|

| | | | |
|------|-------------------|-------|----------|
| City | County (optional) | State | ZIP Code |
|------|-------------------|-------|----------|

Email

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

| | | | |
|----------------|------|-------|----------|
| Street Address | City | State | ZIP Code |
|----------------|------|-------|----------|

By providing an email and telephone number you consent to receiving autodialed and pre-recorded or artificially-voiced healthcare communications, informational and marketing communications, as well as text messages. You can withdraw consent at any time by calling Member Services at (833) 342-7463.

YOUR MEDICARE INFORMATION

Medicare Number _____ - _____ - _____

EMERGENCY CONTACT

| | | |
|------|-------|---------------------|
| Name | Phone | Relationship to You |
| | | |

ANSWER THESE IMPORTANT QUESTIONS

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Doctors HealthCare Plans, Inc.

Yes No If "Yes" please list your other coverage and your (ID) number(s) for this coverage:

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

If applying for a Special Needs Plan, please select one below:

- » If you are enrolling in the **DrExtraCare** Plan, do you have: Chronic Heart Failure Diabetes Mellitus
- » If you are enrolling in the **DrPlus** or **DrPlus-B** Plan, insert your Medicaid Number:

IMPORTANT: READ AND SIGN BELOW

- » I must keep both Hospital (Part A) and Medical (Part B) to stay in Doctors HealthCare Plans, Inc.
- » By joining this Medicare Advantage Plan, I acknowledge that Doctors HealthCare Plans, Inc. 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).
- » I understand that when my Doctors HealthCare Plans, Inc. coverage begins, I must get all of my medical and prescription drug benefits from Doctors HealthCare Plans, Inc. Benefits and service provided by Doctors HealthCare Plans, Inc. and contained in my Doctors HealthCare Plans, Inc. "Evidence of Coverage" documents (also know as a member contract or subscriber agreement) will be covered. Neither Medicare nor Doctors HealthCare Plans, Inc. will pay for benefits or services that are not 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 will 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.

.....
 Signature

.....
 Today's Date

.....
 Witness Signature (if applicable)

.....
 Today's Date

IF YOU'RE THE AUTHORIZED REPRESENTATIVE, SIGN ABOVE AND FILL OUT THESE FIELDS

.....
 Name (Print)

.....
 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.

1. Are you Hispanic, Latino/a, or 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

2. What's your race? Select all that apply.

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

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

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

Please contact Doctors HealthCare Plans, Inc. at (833) 342-7463 if you need information in an accessible format other than what's listed above. Our Member Services hours are 7 days a week, from 8AM to 8PM EST. 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:

.....
Primary Care Physician Name (PCP)

.....
Primary Care Physician ID Number

I want to get the following materials via email (select one or more):

- Evidence of Coverage
- Summary of Benefits
- Provider Directory
- Specific Letters as Requested

E-mail Address:

PAYING YOUR PLAN PREMIUMS

You can pay your monthly 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.**

- By mail each month
- Automatic deduction from your monthly Social Security benefit
- Automatic deduction from your monthly Railroad Retirement Board (RRB) benefit

If you have 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 Doctors HealthCare Plans, Inc. 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 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.

TO BE COMPLETED BY A DOCTORS HEALTHCARE PLANS, INC. LICENSED SALES AGENT

.....
 Licensed Sales Agent Name (if assisted in enrollment)

.....
 Agency Affiliation

.....
 Today's Date

.....
 Licensed Sales Agent Signature

.....
 Licensed Sales Agent Number

LICENSED SALES AGENT — USE THE FOLLOWING CODES FOR APPOINTMENT TYPE

- DHCP Portal
- Paper Application
- Secure Email Application
- Telephonic Enrollment
- Faxed Application
- Mail-in

Doctors HealthCare Plans, Inc., is an HMO with a Medicare contract. Enrollment in Doctors HealthCare Plans, Inc. depends on contract renewal. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (786) 460-3427 o (833) 342-7463 (TTY:711).

| CODE | ENROLLMENT PERIOD STATEMENTS |
|--|--|
| <input type="checkbox"/> IEP/ICEP (Part B) | I am new to Medicare. |
| <input type="checkbox"/> AEP-A | Annual Election Period. |
| <input type="checkbox"/> MAOEP-M | I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP). |
| <input type="checkbox"/> SEP-V | I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on _____ (insert date). |
| <input type="checkbox"/> SEP-V | I recently was released from incarceration. I was released on _____ (insert date). |
| <input type="checkbox"/> SEP-V | I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on _____ (insert date). |
| <input type="checkbox"/> SEP-U | I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid). |
| <input type="checkbox"/> SEP-U | I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on _____ (insert date). |
| <input type="checkbox"/> SEP-L | I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change. |
| <input type="checkbox"/> SEP-T | I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on _____ (insert date). |
| <input type="checkbox"/> S 01 | I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency [FEMA] or by a Federal, state or local government entity.) One of the other statements here applied to me, but I was unable to make my enrollment request because of the natural disaster. |
| <input type="checkbox"/> S 11 | My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan. |
| <input type="checkbox"/> S 22 | I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on _____ (insert date). |
| <input type="checkbox"/> S 27 | I recently left a PACE program on _____ (insert date). |
| <input type="checkbox"/> S 30 | I am applying for a SNP Chronic Condition Plan. |
| <input type="checkbox"/> S 35 | I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on _____ (insert date). |
| <input type="checkbox"/> S 37 | I recently obtained lawful presence status in the United States. I got this status on _____ (insert date). |
| <input type="checkbox"/> LECW | I am leaving my employer or union coverage on _____ (insert date). |
| <input type="checkbox"/> OTH | None of these statements apply to me; however, I feel that I am eligible due to a special circumstance which would allow an exception to enroll (subject to approval). _____ (Please explain) |

If none of these statements applies to you or you are not sure, please contact Doctors HealthCare Plans, Inc. at (833) 342-7463. If you need information in an accessible format or language other than what is listed above, please call our Member Services Department, hours are 7 days a week, from 8AM to 8PM EST. TTY users should call (711).

DISCRIMINATION IS AGAINST THE LAW

Doctors HealthCare Plans, Inc. complies with applicable civil rights laws and does not discriminate or exclude individuals on the basis of race, color, national origin, age disability, sex, sexual orientation, pregnancy, gender, gender identity, or religion.

Doctors HealthCare Plans, Inc. provides: (1) free aids and services to people with disabilities to communicate effectively with us, such as, qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats); and, (2) free language services to individuals whose primary language is not English, such as, qualified interpreters and information written in other languages.

If you need these services, contact the number on the back of your ID Card. If you believe that Doctors HealthCare Plans, Inc., has failed to provide these services or discriminated in any way, you can file a grievance with:

Doctors HealthCare Plans, Inc., Attention: Member Services Department, 2020 Ponce de Leon Blvd., PH 1, Coral Gables, FL 33134 or call (786) 460-3427 or (833) 342-7463, TTY:711; 7 days a week; 8AM to 8PM EST.

You can file a grievance by calling, in person or by mail. If you need help filing a grievance, our Member Services Representatives are available to help you at the number listed above. You can also file a civil rights complaint electronically through the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or call (800) 368-1019, (800) 537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

MULTI-LANGUAGE INTERPRETER SERVICE

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at (833) 342-7463 (TTY:711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al (833) 342-7463 (TTY:711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务,帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务,请致电 (833) 342-7463 (TTY:711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問,為此我們提供免費的翻譯服務。如需翻譯服務,請致電 (833) 342-7463 (TTY:711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamat. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa (833) 342-7463 (TTY:711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au (833) 342-7463 (TTY:711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi (833) 342-7463 (TTY:711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter (833) 342-7463 (TTY:711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 (833) 342-7463 (TTY:711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону (833) 342-7463 (TTY:711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (833) 342-7463 (TTY:711). سيقوم شخص بمساعدتك. هذه خدمة مجانية ما يتحدث العربية.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero (833) 342-7463 (TTY:711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número (833) 342-7463 (TTY:711). Irá encontrar alguém que fale idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan (833) 342-7463 (TTY:711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer (833) 342-7463 (TTY:711). Ta usługa jest bezpłatna.

Hindi: हमारे सवा य या दवा की योजना के बारे में आपके किसी भी परन के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया परापत करने के लिए, बस हमों (833) 342-7463 (TTY:711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Japanese: 当社の健康健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、(833) 342-7463 (TTY:711) にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。