

## 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:

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 (877) 749-3356 (TTY 711).

Or, call Medicare at (800) MEDICARE (800-633-4227). TTY users can call (877) 486-2048.

En español: Llame a FirstMedicare Direct al (877) 749-3356 o a Medicare gratis al (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.**

# First Medicare Direct

FIRSTCAROLINACARE INSURANCE COMPANY

## 2024 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 SmartHMO (HMO)

FIRST Name:

LAST Name:

Middle Initial (Optional):

Birth Date:

(   /    /    )  
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Sex:

Male  Female

Phone Number:

(    )    -

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

City: \_\_\_\_\_ County (Optional): \_\_\_\_\_ 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 (like VA, Tricare) 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.
- 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 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.
- 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:**

**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.

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

- No, not of Hispanic, Latino/a, or Spanish origin       Yes, Puerto Rican  
 Yes, Mexican, Mexican American, Chicano/a       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 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**

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 (877) 749-3356 (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, including any late enrollment penalty that you currently have or may owe, 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. \_\_\_\_\_ /2024

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.



## Discrimination is Against the Law

FirstCarolinaCare Insurance Company complies with applicable Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity).

FirstCarolinaCare Insurance Company does not exclude people or treat them differently because of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity).

FirstCarolinaCare Insurance Company provides free aids and services to people with disabilities to communicate effectively with us, such as:

Qualified sign language interpreters.

Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language services to people whose primary language is not English, such as:

Qualified interpreters.

Information written in other languages.

If you need these services, contact Customer Service. If you believe that FirstCarolinaCare Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity), you can file a grievance with: FirstCarolinaCare Insurance Company, Customer Service, 3310 Fields South Drive, Champaign, Illinois 61822, telephone: (800) 481-1092, fax: (217) 902-9705, [CustomerService@FirstCarolinaCare.com](mailto:CustomerService@FirstCarolinaCare.com).

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Customer Service is available to help you.

You can also file a Civil Rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the 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, HHS Building, Washington, DC 20201, (800) 368-1019, (800) 537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.