MyTru Advantage

OMB No. 0938-1378
Expires:2/28/2029

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN

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 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:
MyTruAdvantage
P.O. Box 428
Columbus, IN 47202

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

How do I get help with this form?
Call MyTruAdvantage at 1-833-213-6731. 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 MyTruAdvantage al 1-844-425-4280/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.

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.

Enrollee Name _____
Agent Name/NPN#_____

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

Select the plan you want to join; premiums per month as shown below: **Effective Date of Coverage: ___ /01/2027**

☐MyTruAdvantage Select (HMO) (MAPD) **$0** ☐ MyTruAdvantage Choice Complete (PPO) (MAPD) **$17.00**

☐MyTruAdvantage Choice Plus (PPO) (MAPD) **$0** ☐MyTruAdvantage Red, White and Tru (PPO) (MA ONLY) **$0**

FIRST name:	LAST name:	Middle Initial (Optional):
Birth date: (MM/DD/YYYY) (__ __ /__ __ / __ __ __ __)	Sex: ☐Male ☐Female	Phone number: ( )

Permanent residence street address (Don't enter a PO Box):
Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

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: __ __ __ __ - __ __ __ - __ __ __ __ Effective Dates: Part A__/__/____ Part B __/__/____

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to MyTruAdvantage: ☐Yes☐No
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 MyTruAdvantage.
- By joining this Medicare Advantage, I acknowledge that MyTruAdvantage 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 MyTruAdvantage coverage begins, I must get all of my medical and prescription drug benefits from MyTruAdvantage. Benefits and services provided by MyTruAdvantage and contained in my MyTruAdvantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor MyTruAdvantage 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 other 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:

Enrollee Name _____
Agent Name/NPN#_____

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 ☐Other: _____

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact MyTruAdvantage at 1-833-213-6731 (TTY: 711) if you need information in an accessible format other than what's listed above. Our office hours are 8:00 a.m. - 8:00 p.m., local time, 7 days a week. On Thanksgiving and Christmas Day, and weekends and holidays from April 1 through September 30 alternate technologies (for example, voicemail) will be used and we will return your call within one (1) business day.

Do you work and have health insurance? ☐Yes ☐ No Does your spouse work and provide you with health insurance? ☐Yes ☐ No Name of other health coverage: _____

List your Primary Care Physician (PCP), clinic or health center:

_____NPI_____

I want to get the following materials via email. Select one or more:

☐Evidence of Coverage ☐Pharmacy Directory

☐Provider Directory ☐Formulary (Drug List)

☐Member Updates (i.e. Newsletters)

Email address: _____

Paying your plan premiums or Late Enrollment Penalty (LEP)

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) 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. DON'T pay MyTruAdvantage the Part D-IRMAA.

If you don't choose a payment option, you will get a bill each month, please select a premium bill option:

☐ Electronic Funds Transfer (EFT) (☐ Checking ☐ Savings) ☐ Social Security (SSA)

☐ Railroad Retirement Board (RRB) ☐ Credit Card ☐ Check

For individuals helping enrollee with completing this form only:

Complete this section if you're an individual (i.e. SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____Relationship to Enrollee: _____

Signature: _____

Agent Use Only: Name of staff member/agent/broker (if assisted in enrollment): _____

Agent Name: _____ Agent NPN #: _____ Plan Name: _____

Effective Date of Coverage: __/__/____

Please read the following statements carefully and check the box if the statement applies to you. By checking any of following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period.

For agents assisting a prospective member, please choose the correct box below:

☐ Initial Enrollment Period (IEP)	☐ Annual Enrollment Period (AEP) (Oct 15 – Dec 7)	☐ Special Enrollment Period (SEP) – Other
☐ Initial Coverage Enrollment Period (ICEP)	☐ Open Enrollment Period (OEP) (Jan 1 – Mar 31)	☐ SEP – Gained lawful presence in the U.S.
☐ Medicare Advantage Open Enrollment Period (MA OEP)	☐ Ongoing SEP – Dual-Eligible or LIS Recipients	☐ SEP – Plan terminated by Medicare
☐ SEP – Moved (change in service area)	☐ SEP – Loss of creditable coverage	☐ SEP – Enrolled in 5-Star plan
☐ SEP – Leaving employer/union coverage	☐ SEP – Loss of Medicaid or Extra Help	☐ SEP – FEMA-declared emergency/disaster
☐ SEP – Gaining Medicaid or Extra Help	☐ SEP – Released from incarceration	☐ SEP – CMS or state error
☐ SEP – Enrolled in or left a PACE program	☐ Other: _____	Date (if applicable): __/__/__

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 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.

MyTruAdvantage is a Medicare Advantage organization with a Medicare contract. Enrollment in MyTruAdvantage plans depends on contract renewal.

MyTruAdvantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.844.425.4280 (TTY: 711).

Enrollee Name _____
Agent Name/NPN#_____