



## TEXAS INDEPENDENCE HEALTH PLAN ENROLLMENT REQUEST FORM

### 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.

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.

### 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:

Texas Independence Health Plan  
1908 N. Laurent Ste. #250  
Victoria, TX 77901

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

### How do I get help with this form?

Call Texas Independence Health Plan at 1-833-471-8447. TTY users can call 1-833-414-8447. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

**En español:** Llame a Texas Independence Health Plan al 1-833-471-8447 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.

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

**Select the plan you want to join:**  Texas Independence Health Plan (HMO I-SNP)  
\$28.40 per month

First Name:	Last Name:	Middle Initial:
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Date of Birth (MM/DD/YYYY) (__ / __ / ____)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone: ( )
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Permanent Residence street address (Don't enter a PO Box):

City:	County:	State:	Zip Code:
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Mailing address, if different from your permanent address (PO Box allowed):

Street address:	City:	State:	Zip Code:
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**Your Medicare information:**

**Medicare Number:**                    - - - - - - - - - -

**Answer these important questions:**

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Texas Independence Health Plan ?

Yes     No

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

\_\_\_\_\_

Are you a resident in a long-term care facility?  Yes     No

If "yes," please provide the following information:

Name of Institution: \_\_\_\_\_

Address & Phone of Institution (number and street): \_\_\_\_\_

\_\_\_\_\_

**IMPORTANT: Read and sign below:**

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Texas Independence Health Plan .
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Texas Independence Health Plan 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 Texas Independence Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Texas Independence Health Plan. Benefits and services provided by Texas Independence Health Plan and contained in my Texas Independence Health Plan “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Texas Independence Health Plan 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:**

If you’re the authorized representative, sign above and fill out these fields:

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.

- |                                                                             |                                                                    |
|-----------------------------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin   | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican                                  | <input type="checkbox"/> Yes, Cuban                                |
| <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin |                                                                    |
| <input type="checkbox"/> <b>I choose not to answer.</b>                     |                                                                    |

What's your race? Select all that apply.

- |                                                           |                                                    |                                                         |
|-----------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Vietnamese                | <input type="checkbox"/> Samoan                         |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Other Asian               | <input type="checkbox"/> Other Pacific Islander         |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Black or African American | <input type="checkbox"/> White                          |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Guamanian or Chamorro     | <input type="checkbox"/> <b>I choose not to answer.</b> |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Native Hawaiian           |                                                         |
| <input type="checkbox"/> Korean                           |                                                    |                                                         |

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

Please contact Texas Independence Health Plan at 1-833-471-8447 if you need information in an accessible format other than what's listed above. Our office hours are 8:00 A.M. to 8:00 P.M., seven days a week from October 1 through March 31; 8:00 A.M. to 8:00 P.M. Monday to Friday from April 1 through September 30. TTY users can call 1-833-414-8447.

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.

- Evidence of Coverage (EOC)  Provider Directory  Pharmacy Directory  ID Card

E-mail address: \_\_\_\_\_

**Section 2, continued – 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.

**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 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 Texas Independence Health Plan the Part D-IRMAA.

**Please select a premium payment option:**

- Get a bill each month
- Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from:  Social Security  RRB

(The Social Security deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

**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.

**Office Use Only:**

Name of staff member/agent/broker (if assisted in enrollment): \_\_\_\_\_

Plan ID # \_\_\_\_\_ Date application received: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

ICEP/IEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP (Type): \_\_\_\_\_ Not Eligible: \_\_\_\_\_

If the form was completed at a Marketing event, put event ID here: \_\_\_\_\_