Fax to:

(866) 819-4774

Attn:

Application Processing

Enrollment Form Submission Cover Sheet

Enrollee's Name:_____Submission Date: _____

Circle One: **Facility** or **Community** Resident Facility Name: _____

- ☐ For I-SNP members, check box if private pay
- ☐ Community Reference Source: _____

Agent's Name: _____

Agent's Phone #:_____Agent's E-mail: _____

Enrollment Form Checklist:

- ☐ Plan Selection (Circle one) H / S / T
- ☐ Personal Info Entered (Ensure mailing address section is done)
- ☐ Payment Method (Circle one)
  - Direct Bill
  - Social Security/Railroad Deduction
- ☐ "Important Questions" Answered
- ☐ Primary Care Physician Selected (if applicable)
- ☐ Election Period Selected
- ☐ Applicant or POA Signature
- ☐ Agent Section Completed w/ proposed effective date
- ☐ Scope of Appointment Form (if required)

For Plan use only

Received by Plan on: _____

Member ID #: _____

6006-d-1 *Internal Use Only*