



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*

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