brand new day

A Bright HealthCare Company

Enrollment Application
ATTN: Enrollment Department
PO Box 93122
Long Beach, CA 90809

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

☐ **Brand New Day Bridges Care Plan (HMO C-SNP)**	$0 per month	MA 28
☐ **Brand New Day Bridges Choice Plan (HMO C-SNP)**	$38.90 per month	DUAL 29

Last name: First name: Middle Initial:

Birth Date:(MM DD YYYY)	Sex:	Home Phone Number:	Cell Phone Number:
__ __ /__ __ /__ __ __ __	☐ Male ☐ Female	(__ __ __) __ __ __ - __ __ __ __	(__ __ __) __ __ __ - __ __ __ __

Permanent Residence Street Address: (Don't enter a PO Box)

City:	County::	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):

Street address: City: State: ZIP Code:

Email Address (Optional): ☐ Permission to send Text Message (Optional):

Your Medicare Information

Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Brand New Day? ☐ Yes ☐ No

Name of other coverage: ID # for this coverage: Group # for this coverage:

Are you enrolled in your State Medicaid program?

If "yes", please provide the following information: ☐ Yes ☐ No

Medicaid ID Number:_____Medicaid DOB:_____

To qualify for Brand New Day Bridges Care Plan (HMO C-SNP) or Brand New Day Bridges Choice Plan (HMO C-SNP) you must have the below chronic condition.

Have you been diagnosed with one of the following?

☐ Dementia

Please also complete the Pre-Enrollment Qualification Assessment Tool (PQAT) included with this form before submitting your application. The PQAT must be submitted with your enrollment form.

IMPORTANT: Read and Sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Brand New Day.
- By joining this Medicare Advantage Plan, I acknowledge that Brand New Day 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).

IMPORTANT: Read and Sign below, continued

- 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 when my Brand New Day coverage begins, I must get all of my medical and prescription drug benefits from Brand New Day. Benefits and services provided by Brand New Day and contained in my Brand New Day "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Brand New Day will pay for benefits or services that are not covered.
- 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 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, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ 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.**

What is your preferred spoken language? _____

Select one if you want us to send you information in a language other than English.

☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean

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

☐ Braille ☐ Large Print ☐ Audio CD

Please contact Brand New Day at 1-866-255-4795 if you need information in an accessible format or language other than what is listed above. Our office hours are Monday - Friday, 8 am - 8 pm and 7 days a week from October 1 - March 31. TTY users can call 711.

Applicant Name: _____

Section 2 – All fields are optional	
Do you work? ☐ Yes ☐ No	Does your spouse work? ☐ Yes ☐ No
Please choose the name of a Primary Care Physician (PCP) and Physician Group:	
PCP Name:	
Physician Group Name:	PCP ID #: ☐ Existing Patient
Please choose the name of a DeltaCare USA Provider:	
Name of Dentist or Facility Name:	
Facility ID:	City:

Paying Your Plan Premium

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. 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 Brand New Day the Part D-IRMAA.

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

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

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.

Applicant Name: _____

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____ /_____ /_____.

☐ I recently was released from incarceration. I was released on (insert date) _____ /_____ /_____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____ /_____ /_____.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____ /_____ /_____.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____ /_____ /_____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____ /_____ /_____.

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) From_____ /_____ /_____ To _____ /_____ /_____.

☐ I recently left a PACE program on (insert date) _____ /_____ /_____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____ /_____ /_____.

☐ I am leaving employer or union coverage on (insert date) _____ /_____ /_____.

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

Applicant Name: _____

Attestation of Eligibility for an Enrollment Period, continued

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____ /_____ /_____.

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____ /_____ /_____.

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact Brand New Day at 1-866-255-4795 (TTY users should call 711) to see if you are eligible to enroll. We are open 7 days a week 8:00 AM - 8:00 PM.

Agent / Broker Information:

Please Read and Sign Below:

- I am licensed and certified by Brand New Day to market and sell the plan
- I have provided a complete and accurate explanation to the beneficiary of the plan's eligibility requirements, benefits, and restrictions, with particular emphasis on the beneficiary's needs
- I have reviewed the application in its entirety to ensure that all fields are complete and accurate to my knowledge

Name of Agent / Broker (if assisted in enrollment): _____

General Agency (GA) Name (if applicable): _____

Agent / Broker Signature (if assisted in enrollment): _____

CA Insurance License No: _____ **Application Receive Date:** _____ /_____ /_____

Proposed Effective Date: _____

Please note: Completed applications must be faxed to Enrollment Department at 1-657-400-1207 within 24 hours of receipt by the broker.

Brand New Day Office Use Only

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ OEP: _____ SEP: _____ LIS: _____ NOT ELIGIBLE: _____