brand new day

HEALTHCARE YOU CAN FEEL GOOD ABOUT

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INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

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:
Brand New Day
ATTN: Enrollment Department
PO Box 93122
Long Beach, CA 90809

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

How do I get help with this form?

Call Brand New Day at 1-866-255-4795. 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 Brand New Day al 1-866-255-4795, 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.

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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 Dual Access Plan (HMO D-SNP) DUAL 24** (AL/CC/FR/IM/KE/KI/LA/MA/OC/PL/RS/SA/SB/SF/SJ/SO/ST/TU/YO) $41.00 per month
- ☐ **Brand New Day Embrace Care Plan (HMO C-SNP) 39-1** (LA/OC/RS/SB/SD) $0.00 per month
- ☐ **Brand New Day Embrace Care Plan (HMO C-SNP) 39-2** (AL/FR/IM/KE/KI/MA/PL/SA/SF/SJ/SM/SC/ST/TU/YO) $0.00 per month
- ☐ **Brand New Day Embrace Choice Plan (HMO C-SNP) 40-1** (LA/OC/RS/SB/SD) $41.00 per month
- ☐ **Brand New Day Embrace Choice Plan (HMO C-SNP) 40-2** (AL/CC/FR/IM/KE/KI/MA/PL/SA/SF/SJ/SM/SC/SO/ST/TU/YO) $41.00 per month
- ☐ **Brand New Day Classic Care III Plan (HMO) 46** (CC/SO) $55.00 per month
- ☐ **Brand New Day Embrace Care Plan (HMO C-SNP) 47** (CC/SO) $55.00 per month
- ☐ **Brand New Day Valor Care Plan (HMO) 48** (FR/IM/KE/KI/LA/MA/OC/RS/SA/SB/SD/SF/SJ/SM/SC/TU) $0.00 per month
- ☐ **Brand New Day Part B Savings Plan (HMO) 49** (LA/OC/RS/SB/SD) $0.00 per month
- ☐ **Brand New Day Classic Care I Plan (HMO) 50-1** (KE/LA/OC/RS/SB/SD) $0.00 per month
- ☐ **Brand New Day Classic Care I Plan (HMO) 50-2** (AL/FR/IM/KI/MA/PL/SA/SF/SJ/SM/SC/ST/TU/YO) $37.60 per month
- ☐ **Brand New Day Classic Care II Plan (HMO) 51-1** (AL/FR/IM/KI/MA/PL/SA/SF/SJ/SM/SC/ST/TU/YO) $0.00 per month
- ☐ **Brand New Day Classic Care II Plan (HMO) 51-2** (KE/LA/OC/RS/SB/SD) $34.30 per month

Last name:	First name:	Middle initial:

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

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:

Applicant Name:_____

Your Medicare Information

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

Part A Effective Date: _____ /_____ /_____ Part B Effective Date: _____ /_____ /_____

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 Embrace Care Plan (HMO C-SNP) or Brand New Day Embrace Choice Plan (HMO C-SNP) you must have one or more of the below chronic conditions.

Have you been diagnosed with one of the following? Please check all that apply.

☐ Diabetes ☐ Congestive Heart Failure ☐ Cardiovascular Disorders

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).
- 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:

Applicant Name:

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	☐ Black or African American
Asian:	Native Hawaiian and Pacific Islander:
☐ Asian Indian	☐ Guamanian or Chamorro
☐ Chinese	☐ Native Hawaiian
☐ Filipino	☐ Samoan
☐ Japanese	☐ Other Pacific Islander
☐ Korean	☐ White
☐ Vietnamese	☐ **I choose not to answer.**
☐ Other Asian	
What is your preferred spoken language? _____	
☐ 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.	
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.

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) _____ /_____ /_____.

Applicant Name:

Attestation of Eligibility for an Enrollment Period, continued

- ☐ 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.
- ☐ 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 have a diagnosis that qualifies me for a Special Needs Plan (C-SNP or D-SNP).
- ☐ 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. Election period missed due to a FEMA related incident: _____

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.

Communication Preferences

Email address **(optional)**: _____

By providing us your email, you are giving consent for the plan to send personalized emails directly related to your health care or health plan.*

*You may opt-out at any time.

Opt-in for Electronic Materials: Send me my health plan materials in electronic format:

☐ Evidence of Coverage ☐ Formulary ☐ Provider Directory ☐ Other required materials

What is the cell phone number you wish to receive text messages on? **(optional)** (_ _ _) _ _ _- _ _ _ _

By providing us your cell phone number, you are giving consent for the plan to send personalized messages directly related to your health care or health plan. This may include benefit information and health and wellness information.*

*You may opt-out at any time. Message and data rates may apply to SMS.

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): _____

FMO (If applicable): _____

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

CA Insurance License No: _____ National Producer Number (NPN): _____

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

Member ID: _____ Effective Date of Coverage: _____ /_____ /_____

Received date: _____ /_____ /_____ Entered Date: _____ /_____ /_____ Initials of Verification:_____

Groups and Part D Premium: _____

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