OMB No. 0938-1378
Expires:7/31/2024

ENROLLMENT REQUEST FORM TO ENROLL IN A DUAL ELIGIBLE SPECIAL NEEDS PLAN (D-SNP)

Who can use this form?

People with Medicare and Medi-Cal who want to join a Dual Eligible Special Needs 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 Dual Eligible Special Needs Plan (D-SNP), you must also have:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)
- Full Scope Medicaid (Medi-Cal)
- Turned 21 years of age at the time of enrollment

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
- Your Medi-Cal 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.

What happens next?

Send your completed and signed form to:

Santa Clara Family Health Plan
Attention: Enrollment Department
PO Box 18880
San Jose, CA 95158

Email: MedicareOutreach@scfhp.com

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

How do I get help with this form?

Call Santa Clara Family Health Plan DualConnect (HMO D-SNP) at 1-888-202-3353. 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 Santa Clara Family Health Plan DualConnect (HMO D-SNP) al 1-888-202-3353/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.

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.

Section 1–All fields on this page are required (unless marked optional)		
Select the plan you want to join: ☐ Santa Clara Family Health Plan DualConnect (HMO D-SNP) - $0 per month		
FIRST name:	LAST name:	Middle Initial (Optional):
Birth date: (MM/DD/YYYY) (/ /)	Sex: ☐ Male ☐ Female	Home phone number: ( )
Cell Phone number: ( )	☐ Yes, I authorize SCFHP DualConnect to text me information about my plan	
Email:	☐ Yes, I authorize SCFHP DualConnect to email me information about my plan	
Permanent Residence street address (Don't enter a PO Box): City: County (Optional): State: ZIP Code:		
Mailing address, if different from your permanent address (PO Box allowed): Street address: City: State: ZIP Code:		
Your Medicare information:		
Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _		
Answer these important questions:		
Will you have other prescription drug coverage (like VA, TRICARE) in addition to Santa Clara Family Health Plan? ☐ Yes ☐ No		
Name of other coverage:	Member number for this coverage:	Group number for this coverage:
Are you enrolled in your state Medicaid (Medi-Cal) program? ☐ Yes ☐ No If "yes," please provide your Medicaid 9-digit number (Client Index Number (CIN)):		

IMPORTANT: Read and sign below:	
• I must keep Hospital (Part A) and Medical (Part B) Medicare coverage, and Medi-Cal to stay in Santa Clara Family Health Plan. • By joining this Medicare Advantage Plan, I acknowledge that Santa Clara Family 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 Santa Clara Family Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Santa Clara Family Health Plan. Benefits and services provided by Santa Clara Family Health Plan and contained in my Santa Clara Family Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Santa Clara Family 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:

AGENT USE ONLY	
Agent Name:	Date:
NPN:	Effective date:

This form continues on the next page

Section 2 – All fields on this section 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, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**
- ☐ Yes, Mexican American, Chicano/a
- ☐ Yes, Cuban

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Chinese
- ☐ Japanese
- ☐ Other Asian
- ☐ Vietnamese
- ☐ **I choose not to answer.**
- ☐ Asian Indian
- ☐ Filipino
- ☐ Korean
- ☐ Other Pacific Islander
- ☐ White
- ☐ Black or African American
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan

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

☐ Spanish ☐ Vietnamese ☐ Simplified Chinese ☐ Tagalog

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

☐ Braille ☐ Large print ☐ Audio CD

Please contact Santa Clara Family Health Plan DualConnect (HMO D-SNP) at 1-877-723-4795 if you need information in an accessible format other than what's listed above. Our office hours are 7 days a week, 8 a.m. to 8 p.m. TTY users can call 711.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

List your Primary Care Provider (PCP), clinic, or health center:

PCP/Clinic address:

NPI (PCP/Clinic Code):

Santa Clara Family Health Plan DualConnect is an HMO D-SNP with a Medicare and Medi-Cal contract. Enrollment in DualConnect depends on contract renewal.

Santa Clara Family Health Plan DualConnect complies with applicable Federal civil rights laws, and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you need help in your language call 1-877-723-4795 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-877-723-4795 (TTY: 711). These services are free of charge.

ATENCIÓN: si necesita ayuda en su idioma, llame al 1-877-723-4795 (TTY: 711). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-877-723-4795 (TTY: 711). Estos servicios son gratuitos.

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-877-723-4795 (TTY: 711). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-877-723-4795 (TTY: 711) . Các dịch vụ này đều miễn phí.

请注意：如果您需要以您的母语提供帮助，请致电 1-877-723-4795 (TTY: 711) 。另外还提供针对残疾人士的帮助和服务，例如文盲和需要较大字体阅读，也是方便取用的。请致电 1-877-723-4795 (TTY: 711)。这些服务都是免费的。

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-877-723-4795 (TTY: 711). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-877-723-4795 (TTY: 711). Libre ang mga serbisyong ito.

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 and 1860D-1 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.

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-NEW. 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.