



American Health Advantage of Missouri
201 Jordan Road, Suite 200
Franklin, TN 37067
1-844-228-7934 (TTY/TDD: 711)
mo.AmHealthPlans.com

American Health Advantage of Missouri Individual Enrollment Request Form

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 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:

American Health Advantage of Missouri
201 Jordan Rd, Ste 200
Franklin, TN 37067

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

How do I get help with this form?

Call American Health Advantage of Missouri at 1-844-228-7934. 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 American Health Advantage of Missouri al 1-844-228-7934/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.

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

Select the plan you want to join:

_____ American Health Advantage of Missouri [H4490-001] – \$30.50 per month

_____ American Health Advantage Plus of Missouri [H4490-002] - \$115.00 per month

FIRST name:

LAST name:

Middle Initial:

Birth date: (MM/DD/YYYY)

(___ / ___ / ___)

Sex:

__ Male __ Female

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: _____

Your Medicare information:

Medicare Number:

_____ - _____ - _____

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to American Health Advantage of Missouri?

_____ Yes

_____ No

Name of other coverage:

Member number for this coverage:

Group number for this coverage

Are you a resident in a long-term care facility, such as a nursing home? Yes No

If "yes," please provide the following information:

Name of Institution: _____

Address & Phone Number of Institution (number and street):

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in American Health Advantage of Missouri.
- By joining this Medicare Advantage Plan, I acknowledge that American Health Advantage of Missouri 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.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my American Health Advantage of Missouri coverage begins, I must get all of my medical and prescription drug benefits from American Health Advantage of Missouri. Benefits and services provided by American Health Advantage of Missouri and contained in my American Health Advantage of Missouri "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor American Health Advantage of Missouri 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:

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

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

Large print

Please contact American Health Advantage of Missouri at 1-844-228-7934 if you need information in an accessible format other than what's listed above. Our office hours are 8:00 A.M. to 8:00 P.M. seven days a week October 1 through March 31; 8:00 A.M. to 8:00 P.M. Monday to Friday April 1 through September 30. TTY users can call 711.

Do you work? Yes No

Does your spouse work? Yes No

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

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail 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 American Health Advantage of Missouri the Part D-IRMAA.

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.