Troy Medicare
Enrollment Request Form

Who can use this form?
People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug 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.

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.

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.
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

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:
  Troy Medicare
  PO Box 30667 PMB 36507
  Charlotte, NC 28230

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

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.

How do I get help with this form

English:
Call Troy Medicare at 1-888-494-8769. 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 Troy Medicare al 1-888-494-8769 / 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.

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.

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

www.troymedicare.com
Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join

☐ Troy Medicare (HMO) $0 per month

☐ Troy Medicare for Dual-eligible Beneficiaries (D-SNP) $0 per month

FIRST name: ___________________________ LAST name: ___________________________ [Optional: Middle Initial]: ___________________________

Birth date: (MM/DD/YYYY) ___________________________ Sex  ☐ Male  ☐ Female Phone number: ___________________________

Permanent Residence street address (Don’t enter a PO Box): ________________________________________________________

City: ___________________________ [Optional: County]: ___________________________ 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 Troy?

☐ YES  ☐ NO Name of other coverage: ___________________________ Member number for this coverage: ___________________________ Group number for this coverage: ___________________________

Are you enrolled in your State Medicaid program?

☐ YES  ☐ NO If yes, please provide your Medicaid number ___________________________
IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Troy Medicare.

- By joining this Medicare Advantage Plan, I acknowledge that Troy Medicare 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 Troy Medicare coverage begins, I must get all of my medical and prescription drug benefits from Troy Medicare. Benefits and services provided by Troy Medicare and contained in my Troy Medicare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Troy Medicare 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: __________________________

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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.

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

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

☐ Braille ☐ Large print ☐ Audio CD

Please contact Troy Medicare at 1-888-494-8769 if you need information in an accessible format other than what’s listed above. Our office hours are 8am to 8pm Eastern Time, Monday to Friday (from October 1 to March 31, 8am to 8pm Eastern Time, 7 days a week). 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:

Providing your email address below will automatically enroll you in paperless delivery of some plan communications.

Many of your required plan communications will be delivered electronically. We will send you an email when new communications (such as: Explanation of Benefits or the Annual Notice of Changes) are available on our website. You can access these communications through any device with an Internet connection such as a computer, tablet, or mobile phone.

Email address: