

SECTION 1: To enroll, all fields in this section are required (unless marked optional)**Please check which plan you want to enroll in:**

Longevity Health Plan of North Carolina, Inc. (HMO I-SNP) - \$3 . 0 per month

If you get Extra Help from Medicare, your monthly plan premium will be lower than what it would be if you didn't get Extra Help from Medicare. Depending on your level of Extra Help, your premium may be anywhere between \$0 and \$3 . 0. If you are full-dual eligible, with Extra Help, your premium would be \$0.

Applicant Information: Male Female

Mr. Mrs. Ms.

Birth Date (MM/DD/YYYY): (____/____/____)

First Name _____ Last Name _____ M.I. ____

Medicare Number (MBI) _____

1. Will you have other prescription drug coverage in addition to Longevity Health Plan of North Carolina, Inc.?

Yes No

IF YES, please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other drug coverage _____

ID for this coverage _____

Group # for this coverage _____

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance program.

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SECTION 1 (continued): To enroll, all fields in this section are required (unless marked optional)

I-SNP ONLY (If you are enrolling in the I-SNP, please fill out this question)

2. Are you a resident of a long-term care facility (LTC) in Longevity Health Plan of North Carolina, Inc. network?

Yes No

IF YES, please fill out the facility information below:

Name of Facility _____

Street Address _____

City _____ State _____ Zip _____

Phone Number of Facility _____

IMPORTANT: Read and sign below

I must keep both Hospital (Part A) and Medical (Part B) to stay in Longevity Health Plan of North Carolina, Inc. By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Longevity Health Plan of North Carolina, Inc. 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 Longevity Health Plan of North Carolina, Inc. coverage begins, I must get all of my medical and prescription drug benefits from Longevity Health Plan of North Carolina, Inc. Benefits and services provided by Longevity Health Plan of North Carolina, Inc. and contained in my Longevity Health Plan of North Carolina, Inc. "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Longevity Health Plan of North Carolina, Inc. 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 of applicant or the responsible party X	Today's Date
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SECTION 1 (continued): To enroll, all fields in this section are required (unless marked optional)

Applicant Contact Information:

Permanent Residence Address (P.O. Box not allowed)

Street _____

City _____ State _____ Zip _____

Phone (_____) _____ Email* (optional) _____

Mailing Address, if different from permanent address

Attn Name _____

Street _____

City _____ State _____ Zip _____

Responsible Party Contact Information (as applicable):

If you're the authorized representative, you must sign previous page and fill out these fields:

First Name _____ Last Name _____

Relationship to Enrollee _____

Phone Cell** Home (_____) _____

Email* (optional) _____

* By providing your email address, you are opting in to receive electronic communication, when available.
If you'd like to opt out of electronic communications, check this box: Opt out

** By providing your cell phone number, you are opting in to receive plan communications via SMS/text message. If you do not wish to receive any plan communications or updates via text message, please opt out: Opt out

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**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.**

1. Are you enrolled in your State Medicaid program? Yes No

IF YES, what is your Medicaid number? _____

2. Do you work? Yes No

Does your spouse work? Yes No

3. Please choose your in-network Primary Care Physician (PCP):

Physician Name: _____

Is this your current physician? Yes No

4. Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an *accessible* format:

- Spanish
- Audio File
- Large Print
- Braille

Please contact Longevity Health Plan of North Carolina, Inc. at 1-888-312-5196 (TTY 711) if you need information in an accessible format or language other than what is listed above. Our office hours are 8:00 am to 8:00 pm ET. TTY users can call (TTY 711).

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Paying Your Plan Premium

For plans with a premium, 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 Longevity Health Plan of North Carolina, Inc. 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) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

OFFICE USE ONLY. Please DO NOT complete unless authorized.

Agent First and Last Name _____

Plan ID _____

Application received date _____ Coverage effective date _____

Select the enrollment period:

- IEP/ICEP
- AEP
- OEPI
- SEP (type) _____
- Not eligible

Signature _____ Date _____