OMB No. 0938-1378
Expires:7/31/2023

Keystone First VIP Choice

Coverage by Vista Health Plan, an independent licensee of the Blue Cross and Blue Shield Association.

Individual Enrollment Request Form

Please contact Keystone First VIP Choice (HMO-SNP) if you need information in another language or format (for example, braille).

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: Keystone First VIP Choice P.O. Box 7137 London, KY 40742-7137 Once they process your request to join, they'll contact you.
How do I get help with this form?	Call Keystone First VIP Choice at **1-855-241-3648**. 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 Keystone First VIP Choice al **1-855-241-3648/711** (TTY) 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:

☐ Keystone First VIP Choice (HMO SNP) – $0 per month

Last name:	First name:	Middle initial (Optional):	☐ Mr. ☐ Mrs. ☐ Ms.
Birth date: (MM/DD/YYYY)		Sex: ☐ M ☐ F	
Phone number:			
Permanent residence street address (Don't enter a PO Box):			
City:			
County (Optional):	State:		ZIP code:

MAILING ADDRESS (IF DIFFERENT FROM YOUR PERMANENT ADDRESS) (P.O. 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 Keystone First VIP Choice (HMO-SNP)?

☐ **Yes** ☐ **No**

Name of other coverage:

Member number for this coverage:

Group number for this coverage

IMPORTANT: READ AND SIGN BELOW

I must keep both Hospital (Part A) and Medical (Part B) to stay in Keystone First VIP Choice

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

This person is authorized under State law to complete this enrollment, and 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:

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 a language other than English.

☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Others

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

☐ Braille ☐ Large print ☐ Audio CD

Please contact Keystone First VIP Choice at **1-855-241-3648** if you need information in an accessible format other than what is listed above. Our office hours are seven 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 Physician (PCP), clinic, or health center:

I want to get the following materials via email. Select one or more.

☐ Summary of benefits ☐ Provider/Pharmacy directory
☐ Formulary ☐ Evidence of coverage

E-mail address:

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:		
Name of staff member, agent, or broker (if assisted in enrollment):		
Plan ID number: 001	Effective date of coverage:	
Application date:		
ICEP/IEP:	SEP (type):	
AEP:	MA OEP:	
Not eligible:	Other:	
NIPR number:	Agent ID:	Agent writing number:
Agent signature:		