



CalOptima Health OneCare (HMO-SNP), a Medicare Medi-Cal Plan 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 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](https://www.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.

What happens next?

Send your completed and signed form to:

CalOptima Health OneCare (HMO D-SNP)
505 City Parkway West, Orange, CA 92868

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

How do I get help with this form?

Call CalOptima Health OneCare at **1-877-412-2734**. 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 CalOptima Health OneCare al **1-877-412-2734**. TTY al **711** o a Medicare gratis al 1-800-633-4227 y oprima el 8 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

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 0938-1378. 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.

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

Select the plan you want to join:

CalOptima OneCare Complete (HMO D-SNP) – \$0 per month

CalOptima OneCare Flex Plus (HMO 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. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:

[Optional: 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 CalOptima Health OneCare? Yes No

Name of other coverage:

Member number for this coverage:

Group 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 both Hospital (Part A) and Medical (Part B) to stay in CalOptima Health OneCare.
- By joining this Medicare Advantage Plan, I acknowledge that CalOptima Health OneCare 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 CalOptima Health OneCare coverage begins, I must get all of my medical and prescription drug benefits from CalOptima Health OneCare. Benefits and services provided by CalOptima Health OneCare and contained in my CalOptima Health OneCare “Evidence of Coverage/ Member Handbook” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CalOptima Health OneCare 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:

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

What is your gender? Select one.

- Woman Man Non-binary I use a different term: _____
 I **choose not to answer**

Which of the following best represents how you think of yourself? Select one.

- Lesbian or gay I use a different term: _____
 Straight, that is not gay or lesbian I don't know
 Bisexual I **choose not to answer**

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

- Spanish Vietnamese Farsi Arabic Chinese Korean

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

- Braille Large print Audio CD Data CD

Please contact CalOptima Health OneCare at **1-877-412-2734** if you need information in an accessible format other than what's listed above. Our office hours are Monday through Friday from 8:00 a.m. to 5:00 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:

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee: _____

Signature: _____ National Producer Number (Agents/Brokers only): _____

Effective Date of Coverage: _____

I EP: A EP: SEP: ICEP (type): _____

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.

CalOptima Health OneCare (HMO D-SNP), a Medicare Medi-Cal Plan, is a Medicare Advantage organization with Medicare and Medi-Cal contracts. Enrollment in CalOptima Health OneCare depends on contract renewal. CalOptima Health OneCare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Call CalOptima Health OneCare Customer Service toll-free at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week. Visit us at www.caloptima.org/OneCare.