Please Contact First+Plus if you need information in another language or format (Braille).

First+Plus Advantage (PPO) $0 monthly premium.

To enroll in First+Plus, please complete the following information:

☐ Mr. ☐ Mrs. ☐ Ms. Sex: ☐ M ☐ F Date of Birth: _____/_____/_____

Last Names: First Name: Middle Initial:

Permanent Residence Street Address (P.O. Box is not allowed):

City: Zip Code:

Mailing Address (only if different from the above):

City: Zip Code:

Home phone number: Cell phone number: Alternate phone number:

Emergency Contact: Phone number: Relationship to you:

E-mail:

Please Provide Your Medicare Insurance Information:

Please choose a Physician of Choice (POC) from the First+Plus Provider Directory: Name: ______________________ Phone number: ______________________ Address: ______________________ City: ______________________	Please use your Medicare Card to complete this section. Please fill in the blanks so they match your red, white and blue Medicare card. **-OR-** Attach a copy of your Medicare card or your letter from Social Security. You must have Medicare Part A and B to join a Medicare Advantage plan.	 **Sample Only** Name: ______________________ Medicare Claim Number: Sex: M ☐ F ☐ ___ ___ ___ - ___ ___ - ___ ___ ___ ___ ___ Is entitled to: Effective date: Hospital (Part A) ____________ Medical (Part B) ____________

___________ Members Initial H4011_FP_15_1070_02_I CMS Approved 09/23/2014

We can send you emails and texts about educational materials, promotional events and other plan communication. We can also send you reminders about our different plan activities. You can cancel this option at any time by contacting our Customer Service Department at 1-888-767-7717 Monday through Sunday from 8:00 am to 8:00 pm. TTY users should call 1-877-672-4242. By making a selection you consent to receive such information.

I authorize First+Plus to send me information through: ☐ **e-mail** ☐ **text messages**.

Please Read and answer these important questions:

1. Are you a new Medicare beneficiary? ☐Yes ☐No

2. Do you or your spouse work? ☐Yes ☐No

3. Do you have End-Stage Renal Disease (ESRD)? ☐Yes ☐No, if you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note from your doctor or records** showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

4. Are you a resident in a long-term care facility, such as a nursing home? ☐Yes ☐No, If "yes" provide the name, address and phone number of the facility: ____.

Please check one of the boxes if you would prefer us to send you information in a language other than English or in another format:
☐Spanish ☐Braille ☐Large print ☐Audio format ☐Other (specify) ____________________________. Please contact First+Plus at 1-877-662-4242 if you need information in another format or language than what is listed above. Our office hours are Monday through Sunday 8:00 am to 8:00 pm. TTY users should call 1-877-672-4242.

PLEASE READ AND SIGN BELOW

By completing this enrollment application, I agree to the following:

- First+Plus Advantage is a Medicare Advantage Plan and has a contract with the Federal Government. I will need to keep my Medicare Parts A and B. **I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan**. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. ***Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available*** (Example: October 15 – December 7 of every year), ***or under certain special circumstances***.

- First+Plus serves a specific service area. If I move out of the area that First+Plus serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of First+Plus Advantage, I have the right to appeal plan decision about payment or services if I disagree. I will read the Evidence of Coverage document from First+Plus when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near U.S. border.

- I understand that beginning on the date First+Plus Advantage coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary First+Plus Advantage provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by First+Plus Advantage and other services contained in my First+Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization**, NEITHER MEDICARE NOR FIRST+PLUS ADVANTAGE WILL PAY FOR THE SERVICES.**

- I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with First+Plus, he/she may be paid based on my enrollment in First+Plus Advantage.

Release of Information:

- By joining this Medicare health plan, I acknowledge that First+Plus will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that First+Plus will release my information to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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 authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (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 from Medicare.

Signature: ____ Todays date: ____________

If you are the **authorized representative**, you must sign above and provide the following information or If signed with an X, a witness should be present and provide the following information: Name: ____ Relationship to you: __________________________

Phone number: ______________________ Address: ____

This information is available for free in other languages. Please call our customer service number at 1-888-767-7717, Monday through Sunday from 8:00 am to 8:00 pm. TTY users should call 1-877-672-4242.

Esta información está libre de costo en otros idiomas. Por favor, llame a nuestro número de Servicio al Cliente al 1-888-767-7717, de lunes a domingo de 8:00 am a 8:00 pm. Usuarios de TTY deben llamar al 1-877-672-4242.

First+Plus Advantage is a PPO plan with a Medicare contract.
Enrollment in First+Plus depends on contract renewal.

P.O. Box 195080
San Juan, PR 00919-5080
www.firstpluspr.com

Office use only: *Name of representative/agent/broker (if assisted in enrollment) and phone number:* ____________________________________

☐ *ICEP* ☐ *IEP* ☐ *AEP* ☐ *Not eligible* ☐ *SEP (type):*_________ *Plan ID #:* ______________ *Coverage Effective date:* _________

__________ Members Initial