GOLD KIDNEY HEALTH PLAN

LET'S CHECK IF YOU CAN JOIN A PLAN RIGHT NOW

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am enrolling during the annual enrollment period from October 15 through December 7.
- ☐ I am new to Medicare (Turning 65 in the next 3 months or reaching 24th month of disability).
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan, or I recently moved, and this plan is a new option for me. I moved on (insert date) _____.
- ☐ I recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I recently left a PACE program on (insert date) _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ☐ I am leaving employer or union coverage on (insert date) _____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact Gold Kidney Health Plan at (888) 376-6188 (TTY 711) to see if you are eligible to enroll. We are available October 1 through March 31 from 8:00 a.m. to 8:00 p.m. local time, 7 days a week (except holidays), and from April 1 through September 30 from 8:00 a.m. to 8:00 p.m. local time, Monday through Friday (except holidays).

GOLD KIDNEY HEALTH PLAN

OMB No. 0938-1378
Expires: 6/30/2026

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

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:

Gold Kidney Health Plan Attn: Enrollment
P.O. Box 285 Portsmouth, NH 03802

Or, fax the completed form to (866) 370-0078.

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

How do I get help with this form?

Call Gold Kidney Health Plan at 844-294-6535. 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 Gold Kidney Health Plan al 844-294-6535/TTY 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.

GOLD KIDNEY HEALTH PLAN

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

Select the plan you want to join:

ARIZONA: Counties: Gila, Maricopa, Pima, Pinal

- ☐ **Gold Heart & Diabetes (HMO-POS C-SNP)** H4869-001
  $0 per month
- ☐ **Gold Heart & Diabetes Complete (HMO-POS C-SNP)** H4869-002
  $10.90 per month
  $0 premium with full Medicaid
- ☐ **Gold Dialysis (HMO-POS C-SNP)** H4869-003
  $0 per month
- ☐ **Gold Dialysis Complete (HMO-POS C-SNP)** H4869-004
  $30.10 per month
  $0 premium with full Medicaid
- ☐ **Gold Circle Heart & Diabetes (HMO-POS C-SNP)** H4869-010
  $0 per month
- ☐ **Gold Circle Dialysis (HMO-POS C-SNP)** H4869-012
  $0 per month
- ☐ **Gold Advantage (HMO-POS MA-PD)** H4869-005
  $0 per month
- ☐ **Gold Loyalty (HMO-POS MA)** H4869-009
  $0 per month

ARIZONA: Counties: Cochise, Coconino, Graham, Navajo

- ☐ **Gold Heart & Diabetes (HMO-POS C-SNP)** H4869-011
  $0 per month
- ☐ **Gold Dialysis (HMO-POS C-SNP)** H4869-013
  $0 per month
- ☐ **Gold Circle Heart & Diabetes (HMO-POS C-SNP)** H4869-010
  $0 per month
- ☐ **Gold Circle Dialysis (HMO-POS C-SNP)** H4869-012
  $0 per month
- ☐ **Gold Advantage (HMO-POS MA-PD)** H4869-005
  $0 per month
- ☐ **Gold Loyalty (HMO-POS MA)** H4869-009
  $0 per month

FLORIDA: Counties: Baker, Broward, Clay, DeSoto, Duval, Hardee, Hendry, Hernando, Hillsborough, Indian River, Manatee, Martin, Okeechobee, Osceola, Palm Beach, Pasco, Pinellas, Sarasota, Seminole, St. Lucie, Sumter

- ☐ **Gold Heart & Diabetes (HMO-POS C-SNP)** H1526-001
  $0 per month
- ☐ **Gold Heart & Diabetes Complete / Salud de Oro Completa (HMO-POS C-SNP)** H1526-002
  $20.30 per month
  $0 premium with full Medicaid

GOLD KIDNEY HEALTH PLAN

☐ **Gold Dialysis (HMO-POS C-SNP)** H1526-003
$0 per month

☐ **Gold Dialysis Complete / Dialisis de Oro Completa (HMO-POS C-SNP)** H1526-004
$8.70 per month
$0 premium with full Medicaid

☐ **Gold Advantage (HMO-POS MA-PD)** H1526-005
$0 per month

☐ **Gold Loyalty (HMO-POS MA)** H1526-006
$0 per month

FLORIDA: Counties: Miami-Dade

☐ **Gold Health / Salud de Oro (HMO-POS C-SNP)** H1526-008
$0 per month

☐ **Gold Heart & Diabetes Complete / Salud de Oro Completa (HMO-POS C-SNP)** H1526-002
$20.30 per month
$0 premium with full Medicaid

☐ **Gold Dialysis / Diálisis de Oro (HMO-POS C-SNP)** H1526-009
$0 per month

☐ **Gold Dialysis Complete / Diálisis de Oro Completa (HMO-POS C-SNP)** H1526-004
$8.70 per month
$0 premium with full Medicaid

First Name:	Last Name:	Middle Initial (Optional):

Birth Date: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Sex: ☐ Male ☐ Female	Phone Number: (__ __ __) __ __ __ - __ __ __ __

Permanent residence street address (don't enter a P.O. Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:	County (Optional):	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: __ __ __ __ - __ __ __ - __ __ __ __

GOLD KIDNEY HEALTH PLAN

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Gold Kidney Health Plan? ☐ Yes ☐ No

Name of other coverage:	Member number for this coverage:	Group number for this coverage:

To qualify for a Heart & Diabetes Chronic Condition Special Needs Plan (C-SNP), you must have one or more of the below chronic conditions.

Have you been diagnosed with one of the following? Please check all that apply.

☐ Congestive heart failure (CHF)
☐ Diabetes mellitus (DM)
☐ Cardiovascular disease (CVD)

Please also complete the Pre-Enrollment Qualification Assessment Tool (PQAT) included with this form before submitting your application. The PQAT must be submitted with your enrollment form.

To qualify for a Dialysis Chronic Condition Special Needs Plan (C-SNP), you must be undergoing one or more of the below services.

☐ Dialysis
☐ Dialysis Services

Please also complete the Pre-Enrollment Qualification Assessment Tool (PQAT) included with this form before submitting your application. The PQAT must be submitted with your enrollment form.

GOLD KIDNEY HEALTH PLAN

IMPORTANT: Read and sign below:

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

GOLD KIDNEY HEALTH PLAN

Section 2 – All fields in this section 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, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **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
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ Not sure
- ☐ **I choose not to answer**

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

- ☐ Spanish

GOLD KIDNEY HEALTH PLAN

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Gold Kidney Health Plan Member Services at (844) 294-6535 if you need information in an accessible format other than what's listed above. Our office hours are 8:00 am to 8:00 pm from October 1 through March 31, 7 days a week; and from April 1 through September 30, 8:00 am to 8:00 pm, Monday through Friday. 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 ☐ Evidence of Coverage ☐ Annual Notice of Change
☐ Required Operational Documents ☐ General Member Correspondence

E-mail Address:

☐ I want to receive SMS / Text messaging from Gold Kidney Health Plan for general member correspondence and alerts.

Phone Number: (__ __ __) __ __ __ - __ __ __ __

Your carrier may charge for SMS messages. You can opt-out of SMS messaging at any time by calling us at (844) 294-6535 (TTY 711).

Thrive® Smartphone Program

Gold Kidney Health Plan offers a smartphone with unlimited talk, text, and data as a supplemental benefit to members who meet certain criteria. There is no monthly charge associated with the smartphone while you are enrolled with Gold Kidney Health Plan. To qualify for this benefit, you must be enrolled in a C-SNP plan **and** qualify for Special Supplemental Benefits for the Chronically Ill (SSBCI).

If you opt-in for this benefit, a representative will contact you after Gold Kidney plan enrollment to enroll in the smartphone program and activate the smartphone.

☐ I want to opt-in for the Thrive smartphone program brought to you by Gold Kidney Health Plan

The benefits mentioned are part of a special supplemental benefit program for the chronically ill. To qualify, members must have at least one of the following chronic conditions: cardiovascular disorder; chronic heart failure; diabetes mellitus; end-stage renal disease (ESRD); chronic kidney disease (CKD).

Please note that an enrollee with one or more of the chronic conditions listed above may not necessarily receive the benefit. To qualify, the member must meet all five of the following requirements: 1) have at least one qualifying chronic condition (see above) **and** 2) be enrolled in a Gold Kidney chronic special needs plan (C-SNP); refer to the plan's Summary of Benefits for specific benefits and coverage amounts **and** 3) be at a high risk for hospitalization or other adverse health outcome **and** 4) require intensive care coordination **and** 5) participate in case management.

Not all members will qualify.

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or "Electronic Funds Transfer (EFT)" or "credit card" 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. DON'T pay Gold Kidney Health Plan the Part D-IRMAA.

Please select a premium payment option

☐ **Monthly Invoice**

☐ **Automatic deduction from your monthly Social Security (SSA) or Railroad Retirement Board (RRB) check.**

The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

☐ **Credit Card Payment**

☐ **Electronic funds transfer (EFT) from your bank account each month**

GOLD KIDNEY HEALTH PLAN

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):
GOLD KIDNEY HEALTH PLAN ADMINISTRATIVE SECTION ***(Licensed Agent Use Only)***	
Plan ID #	Effective Date of Coverage:
Licensed Sales Agent received date:	
Licensed Sales Agent signature (required):	

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 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.