2026 INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

VillageHealth by SCAN Health Plan®

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:

VillageHealth
Attention: Enrollment and Reconciliation
PO BOX 22616
Long Beach CA 90801

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

How do I get help with this form?
Call VillageHealth at (800) 399-7226, 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 VillageHealth al (800) 399-7226 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.

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.

1 All fields in this section are required (unless marked optional)

Select the plan you want to join:

VillageHealth (HMO-POS C-SNP)

☐ H5943-003 Riverside, San Bernardino Counties $6.30 per month

☐ H5943-004 Los Angeles County $12 per month

1 All fields in this section are required (unless marked optional)

First Name: Last Name: M.I. (optional)

Birth Date: / / Sex: ☐ Male ☐ Female

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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.):

Street Address: City:

County: State: ZIP Code:

Mailing Address, if different from your permanent address (PO Box allowed):

Street Address: City:

County: State: ZIP Code:

Your Medicare information:

Medicare Number: - -

Answer these importance questions.

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

Name of other coverage: _____

Member number for this coverage: _____ Group number for this coverage: _____

Are you enrolled in your state Medi-Cal (Medicaid) program? ☐ Yes ☐ No

If "yes" please provide your Medi-Cal (Medicaid) number:

Issue Date: / /

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I qualify to enroll into a Chronic Special Needs Plan? ☐ Yes ☐ No

1 All fields in this section are required (unless marked optional) *(continued)*

IMPORTANT: Read and sign below:

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

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.

Select one if you want us to send you information in a language other than English: ☐ Spanish ☐ Chinese ☐ Korean ☐ Vietnamese

Select one if you want us to send you information in an accessible format. ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD
Please contact VillageHealth at (800) 531-4040 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 5 p.m. PST Monday through Friday. TTY users can call 711.

Do you work? ☐ Yes ☐ No | Does your spouse/partner work? ☐ Yes ☐ No

Please choose the name of a primary care provider (PCP). **If the PCP you chose is not available, an available PCP will be automatically assigned to you.** Primary Care Provider Name: _____

Primary Care Physician Number: ☐☐☐☐☐☐ - ☐☐ Medical Group Number: ☐☐☐☐☐

Are you a current patient of this physician? ☐ Yes ☐ No

Email Address:_____
By providing my email address, I agree to receive electronic communication, when available.
If you'd like to opt out of electronic communications check this box ☐ Opt Out

Mobile Phone Number: (☐☐☐) ☐☐☐ - ☐☐☐☐
By providing your cell number, you are opting in to receive direct and automated plan communications via SMS text messages. If you do not wish to receive any plan communications or updates via text message, check this box ☐ Opt Out

3 Paying your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, 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 VillageHealth the Part D-IRMAA. If you don't select a payment option, you will get a bill each month. Please select a premium payment option:

☐ **Get a bill.**

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

I get monthly benefits from: ☐ Social Security ☐ RRB

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 due 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.

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):

PRIVACY ACT STATEMENT The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) 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.

INTERNAL OFFICE USE ONLY	
NAME OF STAFF MEMBER/AGENT/BROKER (if assisted in enrollment):	NATIONAL PRODUCER NUMBER (NPN):
EFFECTIVE DATE OF COVERAGE: ☐☐ / ☐☐ / ☐☐☐☐	REC'D DATE: ☐☐ / ☐☐ / ☐☐☐☐
☐ EE DUP CONF#	