



## 2025 Johns Hopkins Advantage MD (HMO, HMO D-SNP and PPO) 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.

- 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:  
Johns Hopkins Advantage MD  
P.O. Box 3538  
Scranton, PA 18505  
Fax: 1-855-825-7723

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

### How do I get help with this form?

Call Johns Hopkins Advantage MD at 1-888-403-7662. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048 24 hours a day/7 days a week.

**En español:** Llame a John Hopkins Advantage MD al 1-888-403-7662/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle 24 horas del día, los 7 días de la semana.

### 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 I – All fields on this page are required (unless marked optional)**

**Select the plan you want to join:**

<b>HMO Plans</b>	<b>Available to residents of these counties</b>	<b>Plan Premium</b>	<b>Plan Premium + Optional Comprehensive Dental Benefit</b>
Johns Hopkins Advantage MD D-SNP (HMO)	Anne Arundel, Baltimore Co., Carroll, Frederick, Howard, Montgomery, Somerset, Washington, Wicomico and Worcester	<input type="checkbox"/> \$0 per month* <i>Includes comprehensive dental benefit</i>	
<i>Dual Special Needs Plan for those who are eligible for full Medicare and Medicaid benefits.</i>			
Johns Hopkins Advantage MD (HMO)	Anne Arundel, Baltimore Co., Carroll, Frederick, Howard, Montgomery, Somerset, Washington, Wicomico and Worcester	<input type="checkbox"/> \$20 per month	<input type="checkbox"/> \$45 per month
Johns Hopkins Advantage MD Tribute (HMO) <i>This plan does not include drug coverage.</i>	Anne Arundel, Baltimore Co., Frederick, Howard, Montgomery	<input type="checkbox"/> \$0 per month <i>Includes comprehensive dental benefit</i>	
<b>PPO Plans</b>	<b>Available to residents of these counties</b>	<b>Plan Premium</b>	<b>Plan Premium + Optional Comprehensive Dental Benefit</b>
Johns Hopkins Advantage MD (PPO)	Anne Arundel, Baltimore Co., Carroll, Frederick, Howard, Montgomery, Somerset, Washington, Wicomico and Worcester	<input type="checkbox"/> \$95 per month <i>Includes comprehensive dental benefit</i>	
Johns Hopkins Advantage MD Primary (PPO)	Anne Arundel, Baltimore Co., Frederick, Howard, Montgomery	<input type="checkbox"/> \$0 per month <i>Includes comprehensive dental benefit</i>	
Johns Hopkins Advantage MD Plus (PPO)	Anne Arundel, Baltimore Co., Carroll, Frederick, Howard, Montgomery, Somerset, Washington, Wicomico and Worcester	<input type="checkbox"/> \$135 per month	<input type="checkbox"/> \$160 per month
<p>* <i>Dependent on your level of Extra Help</i>  <i>Please see the Summary of Benefits for more information about Optional Comprehensive Dental Benefits.</i></p>			

FIRST name:		LAST name:		Middle Initial [Optional]:	
Birth date: (MM/DD/YYYY) ( ___ / ___ / _____ )		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Phone number: <input type="checkbox"/> Home phone <input type="checkbox"/> Cell phone (       )	
Alternative phone number [Optional]: <input type="checkbox"/> Cell phone (       )			Email address [Optional]:		
Permanent Residence Street Address (Don't enter a PO Box):					
City:		County [Optional]:		State:	ZIP Code:
Mailing address, if different from your permanent address (PO Box allowed):					
Street address:		City:		State:	ZIP Code:
<b>Your Medicare information:</b>					
Medicare Number:    _ _ _ _ - _ _ _ - _ _ _ _					

**Answer these important questions:**

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

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

**Advantage MD D-SNP:** Do you have Maryland Medical Assistance (Medicaid) and Medicare?  Yes  No  
If yes, please provide your Medicaid number: \_\_\_\_\_

**IMPORTANT: Read and sign below:**

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

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, Cuban
- Yes, Puerto Rican
- Yes, another Hispanic, Latino/a, or Spanish origin
- I choose not to answer**

What's your race? Select all that apply.

- |   |   |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black or African American      |
| <input type="checkbox"/> White                            |   |
| Asian:  | Native Hawaiian and Pacific Islander:                   |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Guamanian or Chamorro          |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Native Hawaiian                |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Samoan                         |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Other Pacific Islander         |
| <input type="checkbox"/> Korean                           |   |
| <input type="checkbox"/> Vietnamese                       | <input type="checkbox"/> <b>I choose not to answer.</b> |
| <input type="checkbox"/> Other Asian                      |   |

What is your gender? Select one.

- |                                     |   |
|-------------------------------------|---|
| <input type="checkbox"/> Woman      | <input type="checkbox"/> I use a different term: _____  |
| <input type="checkbox"/> Man        | <input type="checkbox"/> <b>I choose not to answer.</b> |
| <input type="checkbox"/> Non-binary |   |

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

- |  |   |
|--|---|
| <input type="checkbox"/> Lesbian or gay                        | <input type="checkbox"/> I use a different term: _____  |
| <input type="checkbox"/> Straight, that is, not gay or lesbian | <input type="checkbox"/> I don't know                   |
| <input type="checkbox"/> Bisexual                              | <input type="checkbox"/> <b>I choose not to answer.</b> |

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

- Spanish

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

- Braille     Large print     Audio CD     Data CD

Please contact Johns Hopkins Advantage MD at 1-888-403-7662 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., 7 days a week from October 1 to March 31. From April – September 30, leave a message on weekends and holidays>. 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:

\_\_\_\_\_

## 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)” 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 Johns Hopkins Advantage MD the Part D-IRMAA.

**As a Maryland resident, you may also qualify for the Senior Prescription Drug Assistance Program (SPDAP).** For more information, call 1-800-551-5995 (TTY 1-800-877-5156) Monday – Friday from 8:00 am to 5:00 p.m. Visit them online at <http://marylandspdap.com/>.

Please select a premium payment option. **If you do not select a payment option, you will receive a monthly bill.**

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

- The EFT enrollment process usually takes 4-5 weeks. While you are waiting for EFT, you will receive monthly statements. You must pay your premium directly to **Johns Hopkins Advantage MD at P.O. Box 419169, Boston, MA 02241-9169.**

Please enclose a VOIDED check or provide the following:

Account holder name \_\_\_\_\_

Bank routing number \_\_\_\_\_ Bank account number \_\_\_\_\_

Account type:  Checking  Savings

## 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.

**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.

**Get a monthly bill.**

Payments are due on the first of each month. Make your check, cashier's check or money order payable to **Johns Hopkins Advantage MD** and mail directly to **Johns Hopkins Advantage MD, P.O. Box 419169, Boston, MA 02241-9169.**

## 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): \_\_\_\_\_

### Agent Use Only:

Name of agent (if assisted in enrollment): \_\_\_\_\_

Agent Code: \_\_\_\_\_

FMO Name: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

ICEP/IEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP (type): \_\_\_\_\_ Not Eligible: \_\_\_\_\_

Date: \_\_\_\_\_

## Attestation of eligibility for an enrollment period

**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 new to Medicare.
- 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 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) \_\_\_\_\_

## Cont. Attestation of eligibility for an enrollment period

- 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 an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact Johns Hopkins Advantage MD at 1-888-403-7662. (TTY users should call 711) to see if you are eligible to enroll. We are open 8 a.m.–8 p.m., 7 days a week October 1 to March 31. From April 1 to September 30 the hours are 8 a.m.–8 p.m., Monday–Friday. On weekends and holidays you will need to leave a message.

Johns Hopkins Advantage MD is a Medicare Advantage Plan with a Medicare contract offering HMO and PPO products. Enrollment in Johns Hopkins Advantage MD HMO or PPO depends on contract renewal.