



ENROLLMENT APPLICATION

JANUARY 1, 2025 – DECEMBER 31, 2025

2025 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](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:

Astiva Health
765 The City Drive South #200
Orange, CA 92868

Email: enrollment@astivahealth.com

Once they process your request to join, they will contact you.

HOW DO I GET HELP WITH THIS FORM?

Call Astiva Health at 1-866-688-9021, 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 Astiva Health al 1-866-688-9021/711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en Español y un representante estará disponible para asistirle.

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-NEW. 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.



SALES APPOINTMENT CONFIRMATION FORM

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative).

Please initial below in the box beside the plan type that you want the agent to discuss with you.

☐ **Medicare Health Maintenance Organization (HMO)** A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

☐ **Medicare Chronic Special Needs Plan (C-SNP)** A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. An example of the specific groups served include people who have certain chronic medical conditions.

By signing the form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT affect your current enrollment, nor will it enroll you in a Medicare Advantage Plan, Prescription Drug Plan, or other Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature:	Signature Date:
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If you are the Authorized Representative, please sign above and print below:

Representative's Name:	Your Relationship to the Beneficiary:
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To be completed by Agent:

Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact:	
Agent's Signature:	Date:

[Plan Use Only:]

Astiva Health is an HMO with a Medicare contract. Enrollment in Astiva Health depends on contract renewal.

Attention: If you speak another language, language assistance services, free of charge, are available to you. Call 1-866-688-9021 TTY 711.

*Scope of Appointment documentation is subject to CMS record retention requirements. H1993_045_FUY2025_SOA_C



SECTION 1 – ALL FIELDS IN THIS SECTION ARE REQUIRED (UNLESS MARKED OPTIONAL)

Select the plan you want to join:

SERVICE COUNTIES: **Los Angeles, Orange, Riverside, San Bernardino, San Diego**

- ☐ **Astiva Health Savings Plan (HMO) 001 / \$0 per month**
- ☐ **Astiva Health Premier Plan (HMO) 010 / \$0 per month**
For Extra Plus Benefits, please select one of the following options:
_____ SSBCI Grocery Allowance or _____ OTC/Fitness
- ☐ **Astiva Health C-SNP Deluxe Plan (HMO) 007 / \$0 per month**
- ☐ **Astiva Health C-SNP WOW Plan (HMO) 008 / \$29.70* per month**
*Your premium may be paid by Extra Help

Select the plan you want to join:

SERVICE COUNTY: **Santa Clara**

- ☐ **Astiva Health Savings Plan (HMO) 011 / \$0 per month**
- ☐ **Astiva Health Premier Plan (HMO) 012 / \$0 per month**
For Extra Plus Benefits, please select one of the following options:
_____ SSBCI Grocery Allowance or _____ OTC/Fitness
- ☐ **Astiva Health C-SNP WOW Plan (HMO) 013 / \$29.70* per month**
*Your premium may be paid by Extra Help



YOUR PERSONAL INFORMATION:

First Name:	Last Name:	[Optional: Middle Initial]:
Birth date: (MM/DD/YYYY)	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	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 resident address.):

City:	[Optional: County]:	State:	ZIP Code:
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Mailing address, if different from your permanent address (PO Box allowed):

Street address: _____

City: _____ State: _____ ZIP Code: _____

YOUR MEDICARE INSURANCE INFORMATION:

Medicare Number:

_____-_____-_____



ANSWER THESE IMPORTANT QUESTIONS:

1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Astiva Health?

☐ Yes ☐ No

Effective Date: _____

End Date: _____

Name of other coverage: _____

Member number for this coverage: _____

Group number for this coverage: _____

2. Will you have other prescription drug coverage (like Employer group plan) under your policy or another family member? ☐ Yes ☐ No

If yes, please answer the following:

Name of other coverage: _____

Policy #: _____

Coverage effective date: _____

Member ID #: _____

Group #: _____

3. Are you enrolled in your State Medicaid Program? ☐ Yes ☐ No

If yes, please provide your Medicaid number: _____

4. Pre-Enrollment Qualification Assessment

- If you are enrolling into one of our Special Needs Plan (C-SNP), please complete our Pre-Enrollment Qualification Assessment Form.
- If you are enrolling into either MAPD Plan 010 or Plan 012, please complete the Special Supplemental Benefits for the Chronically Ill (SSBCI) Grocery Request Form.



C-SNP PRE-ENROLLMENT QUALIFICATION ASSESSMENT FORM

Are you enrolling in an Astiva Health (HMO C-SNP) Plan?

☐ Yes

☐ No

If **YES**, you understand this plan is a chronic condition special needs plan (C-SNP). The Centers of Medicare & Medicaid Services (CMS) requires Medicare Advantage Plans offering C-SNP plans to obtain a written verification of your qualifying medical condition(s) below from your physician.

I attest to having one of the conditions below (check all that apply):

- ☐ Diabetes mellitus
- ☐ Chronic venous thromboembolic disorder
- ☐ Cardiac arrhythmia
- ☐ Coronary artery disease
- ☐ Peripheral vascular disease
- ☐ Congestive heart failure
- ☐ Enrollee does not have any of the above chronic condition(s).

I, (print name) _____, understand that I will be disenrolled from the Chronic Special Needs Plan (C-SNP) and enrolled to a different plan if my doctor cannot confirm that I have one or more of the qualifying chronic conditions.

List all the provider (s) who can verify your condition(s):

Physician:	Specialty:
Phone:	Fax:

Physician:	Specialty:
Phone:	Fax:

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SSBCI GROCERY REQUEST FORM

First Name:	Last Name:
DOB:	Medicare Number:

Check the box if you have one of the conditions below:

<input type="checkbox"/> Chronic alcohol and other drug dependency, including cannabis, cocaine, opioid, methamphetamine, sedative, hypnotic or anxiolytic substances.	<input type="checkbox"/> Cancer, any type.
<input type="checkbox"/> Cardiovascular disorders, including cardiac arrhythmia, paroxysmal or chronic atrial fibrillation, ventricular arrhythmia, supraventricular arrhythmia, heart block, sick sinus syndrome, congestive heart failure, coronary arterial disease, atherosclerosis, peripheral vascular disease, cerebral vascular accident, transient ischemic attacks, chronic venous thromboembolic disease.	<input type="checkbox"/> Autoimmune disorders, including psoriasis, systemic lupus erythematosus (SLE), rheumatoid arthritis (RA), Sjogren's, Crohn's disease, ulcerative colitis, celiac disease, Grave's disease, Hashimoto thyroiditis, Addison's disease, multiple sclerosis, vasculitis, pernicious anemia, Guilian Barre's syndrome.
<input type="checkbox"/> Chronic Heart Failure.	<input type="checkbox"/> Hypertension.
<input type="checkbox"/> Hyperlipidemia.	<input type="checkbox"/> Dementia.
<input type="checkbox"/> Chronic and disabling mental health conditions, including schizophrenia, bipolar disorder, compulsive obsessive disorders, paranoid disorders, depression, post-traumatic stress disorder.	<input type="checkbox"/> Chronic lung disorders, including asthma, chronic pulmonary obstructive disease (COPD), emphysema, chronic bronchitis, interstitial lung disease.
<input type="checkbox"/> Diabetes.	<input type="checkbox"/> End-stage liver disease.
<input type="checkbox"/> End-stage renal disease (ESRD).	<input type="checkbox"/> HIV/AIDS.
<input type="checkbox"/> Severe hematologic disorders, including severe anemia, any type of lymphoma, leukemia, hemophilia, blood clotting disease, thrombocytopenia, thrombocytosis.	<input type="checkbox"/> Neurologic disorders, including Alzheimer, Parkinson's disease, chronic migraine, autism spectrum disorder, cerebral palsy, traumatic brain injury, spinal stenosis, polio, muscle dystrophy, epilepsy, spinal cord injury.
<input type="checkbox"/> Stroke, including cerebral vascular accident, transient ischemia attack.	



SSBCI GROCERY REQUEST FORM (CONTINUED)

List all the provider (s) who can verify your condition(s):

Physician:	Specialty:
Phone:	Fax:

Physician:	Specialty:
Phone:	Fax:



IMPORTANT - READ AND SIGN BELOW:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Astiva Health.
- By joining this Medicare Advantage, I acknowledge that Astiva Health 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 Astiva Health coverage begins, I must get all of my medical and prescription drug benefits from Astiva Health. Benefits and services provided by Astiva Health and contained in my Astiva Health “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Astiva Health 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.
- My signature below authorizes the provider listed in this enrollment form and/or my PCP to disclose my health information and/or provide medical records to Astiva Health.
- 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.

Authorization for Disclosure of Information

My signature below authorizes the provider listed in this enrollment form and/or my PCP to disclose my health information and/or provide medical records to Astiva Health.

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 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, 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.

- | | |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black or African American |
| 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"/> White |
| <input type="checkbox"/> Vietnamese | <input type="checkbox"/> I choose not to answer |
| <input type="checkbox"/> Other Asian | |

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

- ☐ Spanish
 ☐ Vietnamese
 ☐ Korean
 ☐ Chinese
 Other: _____

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

- ☐ Braille
 ☐ Large print
 ☐ Audio CD
 ☐ Data CD

Please contact Astiva Health at 1-866-688-9021. If you need information in an accessible format other than what's listed above. The hours of operation are 8:00 AM - 8:00 PM, Monday to Sunday between October 1-March 31 and 8:00 AM - 8:00 PM, Monday - Friday, April 1-September 30. TTY users can call 711.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

I want to get the following materials via email. Select one or more.

- ☐ Evidence of Coverage
 ☐ Formulary
 ☐ Pharmacy Directory
 ☐ Provider Directory



TEXTING AND EMAIL OPT IN:

Mobile Phone Number: (____) ____-____

By providing my number, I agree to receive automated and/or other text messages by Astiva Health for health benefits, services, or any other purpose. Such consent is not a condition of receipt of any service and I can opt out at any time by calling Astiva Health or replying stop to any message.

Email: _____

By providing my email address, I agree to receive Astiva Health communications and materials electronically rather than by U.S. Mail. I understand this would include documents such as the Part C and Part D Explanation of Benefits (EOB), Annual Notice of Change (ANOC) and other materials. I can change back to the U.S. Mail at any time by calling Astiva Health.

YOUR PRIMARY CARE PHYSICIAN INFORMATION:

PCP First Name:	PCP Last Name:	PCP Middle Initial
IPA/Medical Group:		
PCP ID#		Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Contact:	Relationship:	Phone Number:

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):



PAYING YOUR PLAN PREMIUMS

If enrolling in Astiva Health Plan 001, 010 and 007, 011, 012 with a \$0 monthly premium: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. **DO NOT pay Astiva Health the Part D-IRMAA.**

If enrolling in Astiva Health C-SNP WOW 008 or Astiva Health C-SNP WOW 013 with a monthly premium: You can pay your monthly plan premium including any late enrollment penalty that you currently have or may owe by mail. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. **DO NOT pay Astiva Health 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 (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 Office Use Only

Agent/broker:		NPN Number:	
Agency:		Effective Date of Coverage:	
ICEP/IEP:	AEP:	SEP (type):	Not Eligible:

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).

<input type="checkbox"/> 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 or will move on (insert date).	Month	Date	Year
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<input type="checkbox"/> I recently was released from incarceration. I was or will be released on (insert date)	Month	Date	Year
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<input type="checkbox"/> I recently returned to the United States after living permanently outside of the U.S. I moved or will move back to the U.S. on (insert date)	Month	Date	Year
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<input type="checkbox"/> I recently obtained lawful presence status in the United States. I got or will get this status on (insert date)	Month	Date	Year
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<input type="checkbox"/> I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid). This change happened on (insert date)	Month	Date	Year
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<input type="checkbox"/> 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). This changed happened on (insert date)	Month	Date	Year
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☐ 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'm in a State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program

<input type="checkbox"/> I recently moved out of a Long-Term Care Facility (for example, a nursing home or a rehabilitation hospital). I moved on (insert date)	Month	Date	Year
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☐ I live in a Long-Term Care Facility (for example, a nursing home or a rehabilitation hospital).



ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

<input type="checkbox"/> I am new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started. I was notified of getting Medicare on (insert date)	Month Date Year
<input type="checkbox"/> I have had Medicare prior to now, but I am now turning 65.	
<input type="checkbox"/> I left coverage from my employer or union (including COBRA coverage). I left or will leave on (insert date)	Month Date Year
<input type="checkbox"/> I lost other, non-Medicare prescription drug coverage that's as good as Medicare prescription drug coverage (creditable coverage), or my other non-Medicare prescription drug coverage changed and is no longer considered credible. This happened on (insert date)	Month Date Year
<input type="checkbox"/> I already have Hospital (Part A) and recently signed up for Medical (Part B). I want to join a Medicare Advantage Plan.	
<input type="checkbox"/> I lost my Special Needs Plan because I no longer have a condition required for that plan. This happened on (insert date)	Month Date Year
<input type="checkbox"/> I want to join a Special Needs Plan that tailors its benefits to my chronic condition.	
<input type="checkbox"/> I lost my coverage because Medicare ended its contract with my plan. I received a letter from Medicare saying I can join another plan. My plan ended on or will end on (insert date)	Month Date Year
<input type="checkbox"/> I lost my coverage because my plan no longer covers the area that I live or it ended its contract with Medicare.	
<input type="checkbox"/> I recently left a PACE (Programs of All-Inclusive Care for the Elderly). I dropped my coverage on (insert date)	Month Date Year
<input type="checkbox"/> I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. That plan started on (insert date)	Month Date Year
<input type="checkbox"/> In the last 12 months, I joined a Medicare Advantage plan with prescription drug coverage when I turned 65.	
<input type="checkbox"/> I am enrolling in a 5-star Medicare plan.	
<input type="checkbox"/> I am in a plan that has had a star rating of less than 3 stars for the last 3 years. I want to join a plan with a star rating of 3 stars or higher.	
<input type="checkbox"/> I am in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan.	



ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

<input type="checkbox"/> I dropped a Medicare Supplement Insurance (Medigap) policy when I first joined a Medicare Advantage Plan. It's been less than 12 months since I left my Medigap policy. I want to switch to Original Medicare so I can go back to my Medigap policy, and I'm joining a Drug Plan (Part D). My Medicare Advantage started on (insert date)	<table border="1"> <thead> <tr> <th>Month</th> <th>Date</th> <th>Year</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Month	Date	Year			
Month	Date	Year					
<input type="checkbox"/> 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 natural disaster.							
<input type="checkbox"/> I pay a premium for Part A and I signed up for Part B during the General Enrollment Period (January 1-March 31 each year). I want to join a Medicare drug plan (Part D) or Medicare Advantage Plan with drug coverage.							
<input type="checkbox"/> I signed up for Part A (Hospital Insurance) or Part B (Medical Insurance) during a Special Enrollment Period I qualified for because of an exceptional circumstance. I want to join a Medicare Advantage Plan (with or without drug coverage).							
<input type="checkbox"/> I signed up for Part A (Hospital Insurance) or Part B (Medical Insurance) during a Special Enrollment Period I qualified for because of an exceptional circumstance. I want to join a Medicare drug plan (Part D).							
<input type="checkbox"/> Other: _____							
<p>If none of these statements applies to you or you're not sure, please contact Astiva Health at 1-866-688-9021 (TTY users should call 711) to see if you are eligible to enroll. Astiva Health is an HMO with a Medicare contract. Enrollment in Astiva Health depends on contract renewal. We are open 8:00 AM - 8:00 PM, Monday to Sunday between October 1- March 31 and 8:00 AM - 8:00 PM, Monday - Friday, April 1-September 30.</p>							

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 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.