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2026

ENROLLMENT APPLICATION

SERVICING

LOS ANGELES - ORANGE - RIVERSIDE
SAN BERNARDINO - SAN DIEGO
SANTA CLARA

JANUARY 1, 2026 – DECEMBER 31, 2026

astivahealth.com

OMB NO. 0938-1378
Expires: 12/31/2026

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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:
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.

SALES APPOINTMENT CONFIRMATION FORM

The Centers for Medicare and Medicaid Services require 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:
If you are the Authorized Representative, please sign above and print below:	
Representative's Name:	Your Relationship to the Beneficiary:
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:]	

*Scope of Appointment documentation is subject to CMS record retention requirements. H1993_121_SOA_CY2026_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) 015** / $0 per month
- ☐ **Astiva Health C-SNP Deluxe Plan (HMO) 007** / $0 per month
- ☐ **Astiva Health C-SNP WOW Plan (HMO) 008** / $4.40* 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
- ☐ **Astiva Health C-SNP WOW Plan (HMO) 013** / 12.00* per month
  *Your premium may be paid by Extra Help

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YOUR PERSONAL INFORMATION:		
First Name:	Last Name:	[Optional: Middle Initial]:
Birth date: (MM/DD/YYYY)	Sex: ☐ Male ☐ Female	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:

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

   If yes, please provide your Medicaid number: _____

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.

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.

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YOUR PRIMARY CARE PHYSICIAN INFORMATION:		
PCP First Name:	PCP Last Name:	PCP Middle Initial:
IPA/Medical Group:		
PCP ID#		Existing Patient? ☐ Yes ☐ 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.	
Relationship to enrollee: ☐ Agent/Broker ☐ SHIP counselor ☐ Family member ☐ Other _____	
Name:	Signature:
If you are an Agent/Broker, please fill out information below:	
Agency:	National Producer Number (Agents/Brokers only):
Effective Date of Coverage:	☐ ICEP/IEP ☐ AEP ☐ SEP (type):_____

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:

PAYING YOUR PLAN PREMIUMS

If enrolling in Astiva Health Plan 001, 015 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.)

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 or will move on** (insert date).	**Month Date Year**
☐ I recently was released from incarceration. **I was or will be released on** (insert date)	**Month Date Year**
☐ 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**
☐ I recently obtained lawful presence status in the United States. **I got or will get this status on** (insert date)	**Month Date Year**
☐ 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**
☐ 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**
☐ 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 or will move on** (insert date)	**Month Date Year**
☐ I recently left a PACE program. **I left the program on** (insert date)	**Month Date Year**
☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). **I lost my drug coverage on** (insert date)	**Month Date Year**
☐ I am leaving employer or union coverage. **I am leaving on** (insert date)	**Month Date Year**

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD (CONT.)

☐ I'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.	
☐ 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)	**Month Date Year**
☐ 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)	**Month Date Year**
☐ 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.	
☐ Other _____	

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.

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C-SNP PRE-ENROLLMENT QUALIFICATION ASSESSMENT FORM

Complete this form if you are enrolling into one of our Special Needs Plans (C-SNP) – Plan 007, 008, or 013

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) require Medicare Advantage Plans offering C-SNP plans to obtain a written verification of your qualifying medical condition(s) below from your physician.

Clinical Pre-Qualifying Questions

DIABETES	
Have you ever been diagnosed with diabetes?	☐ Yes ☐ No
Have you had problems with high blood sugar?	☐ Yes ☐ No
Do you take medication and/or have you been put on a special diet to control your blood sugar?	☐ Yes ☐ No
Do you check your blood sugar at home?	☐ Yes ☐ No
Have you presented increased thirst, frequent urination, extreme hunger, unexplained weight loss, slow healing sores, or frequent urination?	☐ Yes ☐ No
CARDIOVASCULAR DISORDERS	
Have you been diagnosed by your doctor or other licensed healthcare professional with cardiac arrhythmia, or coronary artery disease (Angina), blood clots or vascular disease of legs?	☐ Yes ☐ No
Have you had pain in your chest?	☐ Yes ☐ No
Have you had or been told you're at risk of having a heart attack?	☐ Yes ☐ No
Have you had problems with chest pain or tightness, shortness of breath, heart attack, or stroke?	☐ Yes ☐ No
Do you have dilated leg veins with discomfort?	☐ Yes ☐ No
Do you have a pacemaker, or do you take any medications for abnormal heart rhythm?	☐ Yes ☐ No
Do you smoke?	☐ Yes ☐ No
CHRONIC HEART FAILURE (CHF)	
Have you been diagnosed by your doctor or other licensed healthcare professional with chronic or congestive heart failure (CHF)?	☐ Yes ☐ No
Do you have high blood pressure?	☐ Yes ☐ No
Have you had problems with fluid retention in your lungs or swelling in your legs due to heart problems?	☐ Yes ☐ No
Do you take medications to prevent legs or hand swelling?	☐ Yes ☐ No
Do you feel fatigue when walking or doing physical activity?	☐ Yes ☐ No

C-SNP PRE-ENROLLMENT QUALIFICATION ASSESSMENT FORM (CONT.)	
When you walk, do you need to stop and rest?	☐ Yes ☐ No
Have you had problems with rapid, erratic heartbeats?	☐ Yes ☐ No
Do you take a water pill due to a heart-related condition (such as heart failure)?	☐ Yes ☐ No
Has a physician ever told you that you have blood clots?	☐ Yes ☐ No
Do you have fluid in your lungs?	☐ Yes ☐ No

MEDICATION QUESTIONS	
Are you now or have you ever taken medication for an illness listed above?	☐ Yes ☐ No
Have you ever taken or currently taking metformin or insulin injections?	☐ Yes ☐ No

CURRENT MEDICATIONS LIST	
Name of Medication	**Strength and Frequency**

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: