HealthPlan OF SAN MATEO
CareAdvantage
Dual Eligible Special Needs Plan (D-SNP)

ENROLLMENT FORM

OMB No. 0938-1378 (Expires 12/31/2026)

CareAdvantage Dual Eligible Special Needs Plan (D-SNP) is a Dual Special Needs Plan with Medicare and Medi-Cal contracts. Enrollment in CareAdvantage D-SNP depends on contract renewal.

Filling out this application is your first step to getting access to a wide range of health care benefits and services. Plus, you can connect with a local team to help you use those benefits so you can stay healthy.

Joining CareAdvantage is easy. You can return this form to HPSM in two ways:

Mail:
Health Plan of San Mateo
C/O Medicare Specialists
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080

or

Fax:
650-829-2015

Who can fill out this form? People with **only** Medicare Parts A & B and HPSM Medi-Cal health coverage

When do I use this form? You can fill out this form to join CareAdvantage:

- During the 3 months of first getting Medicare
- In some situations where you're allowed to join or switch plans (learn more at **www.medicare.gov**)

What do I need to complete this form? You will need your Medicare number (from your red, white and blue Medicare card), your Medi-Cal number, your address and phone number. *If you have no permanent address, a post office box, address of a shelter or clinic, or address of where you receive any mail (social security checks, etc.) may be considered your permanent address.*

How do I get help with this form? HPSM's team of Medicare Specialists is ready to help you sign up for CareAdvantage. Call them at **1-888-252-3153** (toll free) or **650-616-1500** Monday through Friday from 9 a.m. to 6 p.m. TTY users call **1-800-735-2929** or dial **7-1-1**.

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.

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.

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.

HealthPlan OF SAN MATEO

ENROLLMENT FORM

H6019_Enrollment_E 2026

Tell us about yourself (all fields are required unless marked optional):

First Name | Last Name | Middle Initial *(optional)*

Date of Birth (MM/DD/YYYY) | Sex: Male Female | Phone #

Home Address *(where you live)* | City | State | Zip | County *(optional)*

Mailing Address *(if different from home address)* | City | State | Zip | County *(optional)*

Email Address | Emergency Contact | Emergency Contact Phone #

Medicare # (This information can be found on the front of your card.) | Medi-Cal # (*This information can be found on the front of your card.)*

Do you work? Yes No | Does your spouse work? Yes No

Other Prescription Drug Coverage

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

If yes, complete information below:

Name of Coverage | Member ID# | Group ID#

Effective Date (MM/DD/YYYY)

IMPORTANT: Read and sign to acknowledge you understand and complete items on the other side of the page:

- I must keep both Medicare Parts A & B and HPSM Medi-Cal to stay in CareAdvantage.
- I can be enrolled in only one Medicare Advantage plan at a time. Enrollment in any other plan will automatically end when I enroll in CareAdvantage (exceptions are for MA PFFS, MA MSA plans).
- CareAdvantage 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). Your response to this form is voluntary, but failure to respond may affect your enrollment in CareAdvantage.
- When my CareAdvantage coverage begins, I must get all of my medical and prescription drug benefits from CareAdvantage. Benefits and services provided by CareAdvantage and contained in my Evidence of Coverage (EOC) (also known as Member Handbook) will be covered. Neither Medicare nor CareAdvantage will pay for benefits or services that are not covered.
- The information on this 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 CareAdvantage.
- My signature (or signature of the person legally authorized to act on my behalf) on this form means that I have read and understood this form. If signed by an authorized representative (as described previously), this signature certifies that this person is authorized under State law to complete this enrollment and documentation of this authority is available upon request by Medicare or Medi-Cal.

Your Signature | Date

Representative's name (please print) | Representative's signature

Representative's address | City | State | Zip | County *(optional)*

Relationship to enrollee | Representative's phone # | Today's date

Contact CareAdvantage at **1-866-880-0606** if you need information in an accessible format other than what's listed above.
Office hours are Monday – Sunday 8:00 am to 8:00 pm. (TTY: **1-800-735-2929** or **7-1-1**).

COMPLETE ITEMS ON OTHER SIDE

Other Information

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

What is your preferred language?

English Spanish Tagalog Chinese

Russian Other (please list): _____

Do you want your information sent to you in your preferred language? Yes No

Do you need your information sent to you in another accessible format? If yes, select one:

Large print Braille Audio CD Data CD

Other: _____

Current Primary Care Provider, clinic or health center:

National Producer Number (NPN):
(For internal use only) _____