2026 Individual Enrollment Request Form

Who can use this form?
People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug 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)

Important: To join a Medicare Prescription Drug Plan, you must also have either, or 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 three (3) months of first getting Medicare
- In certain situations where you are 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

Please Note: You must complete all items in **Section 1**. The items in **Section 2** are *optional* — you will not be denied coverage because you do not fill it out.

Reminders:
- If you want to join a plan during the Annual Enrollment Period (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 (if applicable). 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.
- Enrollments during the Annual Enrollment Period (October 15 – December 7) will go into effect January 1.

What happens next?
Send your completed and signed form to:

Alameda Alliance for Health
Attn: Alameda Alliance Wellness
Medicare Operations – Sales
1240 South Loop Road
Alameda, CA 94502

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

How do I get help with this form?
Call Alameda Alliance Wellness at **1.877.972.5373**. TTY users can call **1.800.735.2929**. Or call Medicare at **1.800.MEDICARE** (**1.800.633.4227**). TTY users can call **1.877.486.2048**.

En español: Llame a Alameda Alliance Wellness al **1.877.972.5373** 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.

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Section 1: All fields on this page are required (unless marked optional)

Select the plan you want to join:

☒ **Alameda Alliance Wellness (HMO D-SNP)** – $0 per month

First Name: _____ Last Name: _____ Middle Initial (optional): _____

Date of Birth (MM/DD/YYYY): _____ Sex: ☐ Male ☐ Female

Phone Number: _____

Permanent Residence Street Address (Do not enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

_____

City: _____ County: _____

State: _____ Zip Code: _____

Mailing Address (If different from your permanent address. PO Box allowed.):

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email Address (optional): _____

Mobile Number (optional): _____

By providing your phone number and/or email, you consent to allow Alameda Alliance Wellness to contact and communicate with you by calling, texting, or email. You may change this consent at any time by contacting Alameda Alliance Wellness Member Services.

Providing your email address automatically enrolls you in paperless delivery for some of your plan communications. We will send you an email when new communications (for example: Explanation of Benefits or the Annual Notice of Change) are available online.

Your Medicare Information:

Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __

Answer these important questions:

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

Name of Other Coverage: _____

Member Number for This Coverage: _____

Group Number for This Coverage: _____

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

If **Yes**, please provide your Medicaid (Medi-Cal) number: _____

IMPORTANT
Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Alameda Alliance Wellness.
- By joining this Medicare Advantage Plan, I acknowledge that Alameda Alliance Wellness 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 or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Alameda Alliance Wellness coverage begins, I must get all of my medical and prescription drug benefits from Alameda Alliance Wellness. Benefits and services provided by Alameda Alliance Wellness and contained in my Alameda Alliance Wellness "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Alameda Alliance Wellness 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.

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 (1) if you want us to send you information in a language other than English.

☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Tagalog ☐ Farsi

Select one (1) if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Alameda Alliance Wellness Member Services Department at **1.888.88A.DSNP (1.888.882.3767)** if you need information in an accessible format other than what's listed above. Our office hours are Monday – Sunday (seven (7) days a week), 8 am – 8 pm. TTY users can call **1.800.735.2929**.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

List your primary care provider (PCP), clinic, or health center:

_____

Signature: _____ **Today's Date:** _____

If you are the authorized representative, sign above and fill out these fields:

Full Name: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Relationship to Enrollee: _____

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.

Full Name: _____ Relationship to Enrollee: _____

Signature: _____

National Producer Number (Agents/Brokers only): _____

If you have questions regarding the status of your enrollment, please contact Alameda Alliance Wellness Member Services Department at **1.888.88A.DSNP (1.888.882.3767)**, Monday – Sunday (seven (7) days a week), 8 am – 8 pm. TTY users can call **1.800.735.2929**.

Alameda Alliance Wellness is an HMO D-SNP plan with a Medicare contract and a contract with the California State Medi-Cal (Medicaid) Program. Enrollment in Alameda Alliance Wellness depends on contract renewal.

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 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.