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

Capital Health Plan
An Independent Licensee of the Blue Cross and Blue Shield Association

Capital Health Plan Retiree Advantage (HMO)

2026 Enrollment Application

Section 4: Enrollment Information

Employer Information

Employer Name (Retirement Benefits): _____
Group #: _____

State of Florida Members Only:

☐ Retiree Advantage ☐ Retiree Classic

☐ I have contacted People First (1-866-663-4735) to report plan selection and will send a copy of my Medicare card.

Personal Information

- **Last Name:** _____
- **First Name:** _____
- **Middle Initial:** _____
- ☐ Mr. ☐ Mrs. ☐ Ms.
- **Date of Birth (mm/dd/yyyy):** _____
- **Sex:** ☐ Male ☐ Female
- **Home Phone:** _____

Permanent Residence (No P.O. Box)

- **Street Address:** _____
- **City:** _____ **State:** _____ **ZIP:** _____

Mailing Address (If Different)

- **Street Address:** _____

- **City:** _____ **State:** _____ **ZIP:** _____

Emergency Contact (Optional)

- ☐ Yes ☐ No
- **Name:** _____
- **Phone (Home):** _____
- **Phone (Cell):** _____

Medicare Information

Medicare Number (from Red, White, and Blue card): _____
☐ I have both Medicare Part A and B

Section 5: Eligibility Questions

1. **Are you the policyholder?** ☐ Yes ☐ No
   - Retirement Date: _____
   - Last Active Coverage Date: _____

If Yes:
- Covering spouse or dependents? ☐ Yes ☐ No
- Spouse Name: _____
- Dependents: _____

If No:
- Policyholder Name: _____
- Retirement Date: _____
- Last Active Coverage Date: _____

Demographic Information (Optional)

2. **Are you of Hispanic, Latino/a, or Spanish origin?**
   ☐ No ☐ Yes – Select all that apply:
   ☐ Mexican/Mexican American/Chicano/a ☐ Puerto Rican ☐ Cuban
   ☐ Another Hispanic/Latino origin ☐ I choose not to answer

3. **What is your race?** (Select all that apply)
   ☐ American Indian/Alaska Native ☐ Asian Indian ☐ Black/African American
   ☐ Chinese ☐ Filipino ☐ Guamanian/Chamorro ☐ Japanese ☐ Korean
   ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan
   ☐ Vietnamese ☐ White ☐ I choose not to answer

4. **Preferred Language (if not English):**
   ☐ Spanish ☐ Other: _____

Section 6: Additional Coverage and Provider Information

Do you or your spouse work? ☐ Yes ☐ No

5. **Will you have other prescription drug coverage?** ☐ Yes ☐ No
   If Yes:
   - Coverage Name: _____
   - Member ID #: _____
   - Group #: _____

6. **Primary Care Physician (PCP):** _____
   Are you an established patient? ☐ Yes ☐ No

7. **Would you like to receive materials by email?**
   ☐ Evidence of Coverage ☐ Annual Notice of Change
   Email: _____

8. **Would you like information in an accessible format?** ☐ Yes ☐ No
   If Yes, select one:
   ☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Section 7: Enrollment Agreement

By completing this application, I agree to the following:

- I will keep both Medicare Part A and B to remain enrolled.
- I authorize Capital Health Plan to share my information with Medicare for processing.
- I confirm that the information I provided is accurate.

- I understand I must use Capital Health Plan providers.
- I understand Medicare won't pay for out-of-network services unless specified.
- I agree my signature or that of my authorized representative validates this application.

Privacy Act Statement

Capital Health Plan may share your information with CMS as allowed by federal law. You are not required to respond, but failure to do so may affect enrollment.

Enrollment Confirmation

Confirmation Number: _____
Date of Application: _____

Authorized Representative (If Applicable)

- **Name:** _____
- **Phone:** _____
- **Address:** _____
- **Relationship to Enrollee:** _____

Office Use Only

- **Agent/Broker Name:**
- **Agent/Broker Number:** _____
- **Application Date:** _____
- **Effective Coverage Date:** _____
- **Eligibility Code:**
  ☐ ICEP/IEP ☐ AEP ☐ SEP (Type): _____ ☐ STAR (R) ☐ Not Eligible
- **Method of Contact:**

Section 8: Special Enrollment Period (SEP) Checkboxes

Please check all that apply if applying **outside of the October 15 - December 7** annual enrollment period:

☐ I am new to Medicare
☐ I am making a change during MA OEP
☐ I recently moved (Date:_____)
☐ I was recently released from incarceration (Date:_____)
☐ I returned to the U.S. (Date:_____)
☐ I recently gained lawful presence (Date:_____)
☐ Change in Medicaid (Date:_____)
☐ Change in Extra Help (Date:_____)
☐ I have both Medicare and Medicaid
☐ I live or moved into/out of a long-term care facility (Date:_____)
☐ I left a PACE program (Date:_____)
☐ I involuntarily lost drug coverage (Date:_____)
☐ I left employer/union coverage (Date:_____)
☐ I belong to a state pharmacy assistance program
☐ My plan is ending contract with Medicare
☐ I lost SNP eligibility (Date:_____)
☐ I was affected by FEMA-declared emergency
☐ My current plan is in receivership
☐ I am in a plan marked with low-performing icon (LPI)

Final Steps

MSR Statement:

This completes the application. Do you have any questions?
☐ Yes ☐ No (Answer questions if yes)

You will receive confirmation of your enrollment within 10 days, followed by your plan documents and ID cards.

Signature/Confirmation Number Format:

Plan ID (e.g., H5938 802 or H5938 804) + Application # (e.g., 00001) + Date (MMDDYYYY)