IMPERIAL HEALTH PLAN OF CALIFORNIA

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)

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 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: **Imperial Health Plan of California (HMO) (HMO SNP)**
Attention: Enrollment
P.O. Box 60874
Pasadena, CA 91116

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

How do I get help with this form?

Call Imperial Health Plan at 1-800-838-5197. 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 Imperial Health Plan al 1-800-838-5197/TTY 711 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.

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. See "What happens next?" on this page to send your completed form to the plan.

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Section 1 – All fields in this section are required (unless marked optional)

Select the plan you want to join:

☐ Imperial Senior Value (HMO C-SNP) 005 – <$0> Part C/D

☐ Imperial Dynamic Plan (HMO) 012 – <$0> Part C/D

☐ Imperial Courage Plan (HMO MA-only) 016 – <$0> Part C Only

First name:	Last name:	Middle initial: (optional)
Birth date (MM/DD/YYYY):	Sex: ☐ Male ☐ Female	Phone number:
Email Address (optional):		Cell Phone (optional):

Permanent residence street address (Don't enter a P.O. Box. Note: For individuals experiencing homelessness, a P.O. Box may be considered your permanent residence address.):

City:	County: (optional)	State:	ZIP code:

Mailing address, if different from your permanent address (P.O. Box allowed):

Street address:	City:	State:	ZIP code:
Emergency Contact (optional):	Relationship:	Phone Number:	

Your Medicare information:

Medicare number:

__ __ __ __ - __ __ __ - __ __ __ __

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Imperial Health Plan?

☐ Yes ☐ No

Name of other coverage:	Member number for this coverage:	Group number for this coverage:

Do you have cardiovascular disorder, chronic heart failure, and/or diabetes? ☐ Yes ☐ No

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

If "yes," please provide your Medi-Cal (Medicaid) number: _____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Imperial Health Plan.
- By joining this Medicare Advantage or Medicare Prescription Drug Plan, I acknowledge that Imperial Health Plan 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 Imperial Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Imperial Health Plan. Benefits and services provided by Imperial Health Plan and contained in my Imperial Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Imperial Health Plan 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.

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.

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

☐ Spanish ☐ Chinese ☐ Korean ☐ Vietnamese ☐ Other _____

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Imperial Health Plan at 1-800-838-8271 if you need information in an accessible format other than what's listed above. Our office hours are October 1 through March 31, Monday through Sunday from 8:00 am to 8:00 pm and April 1 through September 30, Monday through Friday from 8:00 am to 8:00 pm except holidays. TTY users can call 711.

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

List your Primary Care Physician (PCP), clinic, or health center:

PCP Name: _____ PCP ID Number: _____

Medical Group or IPA: _____

Are you an existing patient of this PCP? ☐ Yes ☐ No

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

☐ Yes, I would like to receive my new member Enrollment Kit – EOC, Comprehensive Drug Formulary, and Provider/Pharmacy Directory.

Email address:

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month. Please select a premium payment option. If you don't make a selection, you will receive a bill.**

☐ Get a bill.

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. *The Social Security/RRB deduction may take at least two months to begin after approval by Social Security or the Railroad Retirement Board (RRB). Until Social Security approves the deduction, you will continue to receive paper statements.*

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay Imperial Health Plan the Part D-IRMAA.

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 (NPN):

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.

Imperial Health Plan is an (HMO) (HMO SNP) with a Medicare Contract. Enrollment in Imperial Health Plan depends on contract renewal. Imperial Health Plan of California (HMO) (HMO SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-838-8271 (TTY: 711). Imperial Health Plan of California (HMO) (HMO SNP) cumple con las leyes federales de derechos civiles aplicables y no discrimina por cuestiones de raza, color, nacionalidad, edad, discapacidad o género. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-838-8271 (TTY: 711).