

2026 MCS Classicare (HMO) Enrollment Request Form

Effective Date (MM/DD/YYYY): _____

SOA #: _____

Select the plan you want to join:

- | | |
|---|---|
| ☐ MCS Classicare Efectivo (HMO) PBP 005 | ☐ MCS Classicare Primero (HMO C-SNP) PBP 038 |
| ☐ MCS Classicare En Tu Hogar (HMO) PBP 043 | ☐ MCS Classicare RxMax (HMO) PBP 059 |
| ☐ MCS Classicare Essential (HMO-POS) PBP 008 | ☐ MCS Classicare Platino Ideal (HMO D-SNP) PBP 002 |
| ☐ MCS Classicare Estrella (HMO) PBP 060 | ☐ MCS Classicare Platino 185 (HMO D-SNP) PBP 062 |
| ☐ MCS Classicare Excede (HMO) PBP 056: | ☐ MCS Classicare Platino Máximo (HMO D-SNP) PBP 054: |
| ☐ Region 1 ☐ Region 2 ☐ Region 3 | ☐ Region 1 ☐ Region 2 ☐ Region 3 |
| ☐ MCS Classicare Firme (HMO) PBP 042 | ☐ MCS Classicare Platino Superior (HMO D-SNP) PBP 061 |
| ☐ MCS Classicare Hero (HMO) PBP 044 | ☐ MCS Classicare Platino Progreso (HMO D-SNP) PBP 017 |
| ☐ MCS Classicare InteliCare (HMO) PBP 052 | ☐ MCS Classicare Platino Total (HMO D-SNP) PBP 046 |
| ☐ MCS Classicare Patriot (HMO) PBP 016 | |

\$0 monthly premium (all plans)

Previous medical plan:

☐ MMM ☐ SSS ☐ Humana ☐ Original Medicare ☐ Other, specify: _____

Beneficiary Information:

Last name: _____ Name: _____ Initial: _____

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

Home phone number: _____ Alternate phone number: _____

Permanent Residence Street address (Urbanization or Condominium. PO Box is not allowed. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address):

House or Apartment Number: _____ Street Name or Number: _____

City: _____ State: PR Zip Code: _____

Mailing Address (Urbanization or Condominium), if different from your permanent address (PO Box allowed):

House or Apartment Number: _____ Street Name or Number: _____

City: _____ State: PR Zip Code: _____

Your Medicare Information:

Name (as it appears on your Medicare card): _____

Medicare Number: _____

Hospital (Part A) Effective Date (MM/DD/YYYY): _____

Medical (Part B) Effective Date (MM/DD/YYYY): _____

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

Paying Your Plan Premium:

For all plans, except MCS Classicare Platino (HMO D-SNP): 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, with debit and credit cards (ATH, American Express, Mastercard or Visa), money order or by check in the Service Centers. Also, you may pay by phone through our Member Services Center or in our website, each month. **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 have to pay 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 MCS Classicare (HMO) the Part D-IRMAA.

There are programs in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your local Medical Assistance (Medicaid) office to find out more about their rules. Or call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week and say "Medicaid" for more information. TTY users should call 1-877-486-2048. You can also visit <https://www.medicare.gov> for more information.

Premium Payment Method, if applicable:

If you don't select a payment option, you will get a coupon book.

Please select a premium payment option:

- ☐ Get a coupon book for payment (L) through any Banco Popular branch, by mail or in any Service Center.
- ☐ Automatic withdrawal from your bank account each month (P). Please include a VOIDED check or provide the following:
- Account holder name: _____
- Bank routing number: _____ Bank account number: _____
- Account type: ☐ Checking ☐ Savings
- ☐ Credit Card:
- Card Type: ☐ Visa ☐ MasterCard ☐ American Express
- Account holder name: _____
- Card number: _____
- Expiration date: _____
- ☐ Automatic deduction from your monthly Social Security (W) or Railroad Retirement Board (RRB) benefit check.
- I get monthly benefits from: ☐ Social Security ☐ RRB

(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 accept 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.)

- ☐ You can make your payment through our website. To use the service, you should:
- a) Access www.mcsclassicare.com. b) Once you access the page, you will see an option on the center of the screen titled "Mi MCS." Click on the link. c) You will see a box to the right side of the screen. If you are a new user, you must sign up. Click on "Register." d) Once you have logged in to the registration page, complete the "Registration Form." You will need your plan's identification card. Have it on hand. When your payment is done, the system will give you a confirmation number.

Answer these Important Questions:

1. Are you new to Medicare? ☐ **Yes** ☐ **No**
2. Are you enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP)? ☐ **Yes** ☐ **No**
3. Have you recently moved from your current plan's service area, and this plan is a new option for you or were you released from incarceration recently? ☐ **Yes** ☐ **No**
If "Yes" please provide the date you moved or were released: _____
If "Yes," MCS Advantage becomes aware of your move on the date this application is signed.
4. Are you enrolled in the State Medicaid Program, or have you recently received Medicaid? ☐ **Yes** ☐ **No**
If "Yes", please provide your Medicaid Number (MPI): _____
5. Were you enrolled in a Special Needs Plan C-SNP or D-SNP, but you lost the special need qualification required to be in that plan? ☐ **Yes** ☐ **No**
If "Yes", please provide the date you were notified of the loss of eligibility: _____
6. Did you recently involuntarily lose your creditable prescription drug coverage, coverage as good as Medicare's (i.e., employer or union coverage) or are you leaving employer or union coverage? ☐ **Yes** ☐ **No**
If "Yes", please provide the date: _____
7. Have you obtained lawful presence status in the United States recently? ☐ **Yes** ☐ **No**
If "Yes", please provide the date you obtained lawful presence status: _____
8. Were you affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)? One of the other statements here applied to you, but you could not make your enrollment because of the natural disaster. ☐ **Yes** ☐ **No**
9. If you selected **MCS Classicare Primero (HMO C-SNP)**, you should know that this plan is designed to meet the specialized needs of people who have certain medical conditions. Please indicate which one of these chronic condition makes you eligible:
☐ **Diabetes Mellitus** ☐ **Congestive Heart Failure** ☐ **Cardiovascular Disorder** (Cardiovascular arrhythmias, Coronary artery disease, Peripheral vascular disease, or Chronic venous thromboembolic disorder)

Giving us your VA benefits private information is voluntary. VA eligibility will not affect your Medicare or MCS Classicare (HMO) eligibility or enrollment.

10. Are you a Veteran? ☐ **Yes** ☐ **No**
11. Are you the spouse of a Veteran? ☐ **Yes** ☐ **No**
12. Will you have another medical/hospital insurance or prescription drug coverage in addition to MCS Classicare (HMO), such as a private insurance, TRICARE, Federal Employee Health Benefits Coverage, Veterans Benefits or State pharmaceutical assistance programs? ☐ **Yes** ☐ **No**
If "Yes", please provide us with your other coverage and identification number for this coverage:
Name of Plan: _____ Contract Number: _____
Employer's Name: _____ Group Number: _____
Look on your other prescription drug plan card to complete the following information:
Rx Bin: _____ Rx PCN: _____ Rx Group: _____

13. Do you reside in a long-term care facility, such as a senior center or a nursing home? ☐ Yes ☐ No

If "Yes", please provide us the following information:

Name of the institution: _____

Institution Phone number: _____

Name of the person in charge of the institution: _____

14. Do you have Advance Directives? ☐ Yes ☐ No

Primary Care Physician (PCP) Information:

Please choose the name of a Primary Care Physician (PCP):

Primary Care Physician (PCP) Name: _____

Primary Care Physician Group Number: _____

Informational Materials:

Please check one of the boxes below if you would prefer us to send you information material in a language other than English or in accessible format:

Other Format: ☐ Audio CD ☐ Braille ☐ Large Print ☐ Data CD

Other Language: ☐ Spanish ☐ Other: _____

Please contact our MCS Classicare Member Services at 787.620.2530 (Metro Area) or 1.866.627.8183 (Toll Free) if you need information in an accessible format or language other than what's listed above. Our operation hours are Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30. Customer message system is available for members to leave a message after regular business hours or holidays. TTY users should call 1.866.627.8182 (hearing impaired).

Do you authorize MCS Classicare (HMO) to send you the following documents by email: Providers and Pharmacies Directory, Annual Notice of Changes, Evidence of Coverage, Summary of Benefits, Prescription Drugs Formulary, Durable Medical Equipment Formulary, promotional material, educational material, among other plan communications? ☐ Yes ☐ No

If "Yes", please provide your email address: _____

Do you authorize MCS Classicare (HMO) to send you text messages related to your health services? ☐ Yes ☐ No

If "Yes", please provide your cell phone number _____

What is your preferred communication method? * ☐ Call ☐ Mail ☐ Email * Please note that some regulatory materials may be delivered using a different communication method than the one you selected.

After enrollment, if you do not wish to receive communications by email or text messages to your cell phone, or if you want to change your preferred communication method you can contact our Member Services: 787.620.2530 (Metro Area), 1.866.627.8183 (Toll Free). Our operation hours are Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30. Customer message system is available for members to leave a message after regular business hours or holidays. TTY users should call 1.866.627.8182 (hearing impaired).

Read This Important Information:

If you currently have health coverage from an employer or union, joining MCS Classicare (HMO) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join MCS Classicare (HMO). Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

IMPORTANT: Read and Sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in MCS Classicare (HMO).
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that MCS Classicare (HMO) 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 MCS Classicare (HMO) coverage begins, I must get all my medical and prescription drug benefits from MCS Classicare (HMO). Benefits and services provided by MCS Classicare (HMO) and contained in my MCS Classicare “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor MCS Classicare (HMO) 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.
- I Consent to the disclosure and exchange of information between the U.S. Department of Health and Human Services (HHS), its designees and the MA or Part D plan; information may be used to track enrollment and other purposes, as allowed under federal law and Regulations.

I hereby acknowledge receipt of the following documents provided by Sales Representative or Agent:

- ☐ H5577 Plan Ratings
- ☐ Advanced Directives
- ☐ Notice of Availability Auxiliary Aids and Services
- ☐ Instructions on how to access the Providers and Pharmacies Directory, the Evidence of Coverage, and the Prescription Drug Formulary, as applicable.
- ☐ Model of Care (MOC) – **Platino and C-SNP only**
- ☐ Summary of Benefits
- ☐ Pre-Enrollment Checklist
- ☐ Non-Discrimination Notice
- ☐ Opt-Out document
- ☐ Other: _____

I also, certify that the Sales Representative or Agent has oriented me about the Use and/or Disclosure of Protected Health Information Authorization Formulary.

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

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

Name: _____

Address: _____

Phone Number: _____ **Relationship to Enrollee:** _____

MCS Classicare is an HMO plan offered by MCS Advantage, Inc.

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: _____ **Signature Date:** _____

National Producer Number (Agents/Brokers only): _____

Office Use Only:

Agent ID Number: _____

ICEP/IEP: _____ AEP: _____ MA OEP: _____ SEP (type): _____ Not eligible: _____ Plan ID # _____

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.