



2025 MCS Classicare (HMO) Enrollment Request Form

Effective Date (MM/DD/YYYY): _____

SOA #: _____

Select the plan you want to join:

- MCS Classicare Del Caribe (HMO) PBP 057
- MCS Classicare Efectivo (HMO) PBP 005
- MCS Classicare En Tu Hogar (HMO) PBP 043
- MCS Classicare Essential (HMO-POS) PBP 008
- MCS Classicare Exacto (HMO) PBP 053
- MCS Classicare Excede (HMO) PBP 056:
 - Region 1 Region 2
- MCS Classicare Firme (HMO) PBP 042
- MCS Classicare Hero (HMO) PBP 044
- MCS Classicare InteliCare (HMO) PBP 052
- MCS Classicare Metro (HMO) PBP 051
- MCS Classicare Patriot (HMO) PBP 016
- MCS Classicare Primero (HMO C-SNP) PBP 038
- MCS Classicare RxMax (HMO) PBP 059
- MCS Classicare Platino Ideal (HMO D-SNP) PBP 002
- MCS Classicare Platino Máximo (HMO D-SNP) PBP 054:
 - Region 1 Region 2 Region 3
- MCS Classicare Platino MásCa\$h (HMO D-SNP) PBP 029
- MCS Classicare Platino Progreso (HMO D-SNP) PBP 017
- MCS Classicare Platino Total (HMO D-SNP) PBP 046

\$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 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 (ZIP + 4 Code): _____

Mailing Address (Urbanization or Condominium), if different from your permanent address.

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

City: _____ State: PR Zip Code (ZIP + 4 Code): _____

Answering the following questions is optional. You can't be denied coverage because you don't fill them out.

1. Are you Hispanic, Latino(a), or Spanish origin? Select all that apply.
- Yes, Puerto Rican
 - Yes, Mexican, Mexican American, Chicano(a)
 - Yes, Cuban
 - Yes, another Hispanic, Latino(a), or Spanish origin
 - No, not of Hispanic, Latino(a), or Spanish origin
 - I choose not to answer.

2. What's your race? Select all that apply.

White

Black or African American

American Indian or Alaska Native

Native Hawaiian and Pacific Islander:

Guamanian or Chamorro

Native Hawaiian

Samoan

Other Pacific Islander

Asian:

Asian Indian

Chinese

Filipino

Japanese

Korean

Vietnamese

Other Asian

I choose not to answer.

3. What is your gender? Select one.

Woman

Man

Non-binary

I use a different term: _____

I choose not to answer.

4. Which of the following best represents how you think of yourself? Select one.

Straight, that is, not gay or lesbian

Lesbian or gay

Bisexual

I use a different term: _____

I don't know.

I choose not to answer.

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): _____

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 Service Call 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 are assessed 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 on 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)**, please indicate which chronic condition you were diagnosed with:

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 Service Call Center 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 and other communications from the plan? **Yes** ____ **No** ____

If “Yes”, please provide your cell phone number _____

After enrollment, if you do not wish to receive communications by email or text messages to your cell phone, you can contact our Service Call Center: 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. 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 hereby acknowledge receipt of the following documents provided by Sales Representative or Agent:

- H5577 Plan Ratings
- Advanced Directives
- Multi-Language Insert

- 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 subscribed 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 # _____