

City of Elizabeth Group Health Plan Enrollment Request Form



Please return application to Group, Union, and/or Broker when completed.

To enroll in a Braven HealthSM Medicare Advantage Group plan, please provide the following information:

Employer or Union Name: CITY OF ELIZABETH, NJ

Medicare Advantage Group # (if known): _____

Please Provide Information About You *(Please print clearly)*

Medicare number: _____

Requested effective date of coverage: _____

Birth Date: _____

Sex: ☐ M ☐ F

Phone Number: _____

☐ Mr. ☐ Mrs. ☐ Ms.

LAST Name: _____

FIRST Name: _____ Middle Initial: _____

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.)

Apt./Unit No.: _____

City: _____ State: _____ ZIP Code: _____

Mailing Address (only if different from your Permanent Residence Address):

Street Address: _____

Apt./Unit No. : _____

City: _____ State: _____ ZIP Code: _____

Email Address: (optional)* _____

If you want to join a plan but have no permanent residence, 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.

*By providing your email address, you agree to receive select educational and marketing communications from Braven Health via email.

H0885_ECNA0024546_C

Please Read and Answer These Important Questions

1. Are you the retiree? ☐ Yes ☐ No If yes, retirement date (month/date/year): _____
If no, name of retiree: _____

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

3. Some individuals may have other drug coverage, such as private insurance, state programs, VA, or TRICARE.

Will you have any other coverage in addition to your Braven Medicare Group plan? ☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____

Member number for this coverage: _____

Group number for this coverage: _____

Please provide information about your Primary Care Provider (PCP) or the name of the clinic or health center where you get routine care. If you don't have a PCP, you can search for one at BravenHealth.com/find-doctor.

PCP/Clinic/Health Center name and address: _____

Please provide the "JCD" code for your PCP. The JCD code begins with a letter and is followed by four numbers. To find the JCD code, search for your PCP at BravenHealth.com/find-doctor. Once you find your PCP, click on their name. The JCD code appears in the "Identifiers" section at the bottom of your PCP's profile. If you do not provide this code, we may need you to provide your PCP information after you become a Braven Health member.

Code: _____

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

☐ Spanish ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Braven Health at **1-833-272-8360** if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., Eastern Time, weekdays, April 1 through September 30, and seven days a week, October 1 through March 31. TTY users can call **711**.

IMPORTANT: Read and sign below:

By completing this enrollment application, I agree to the following:

- Braven Medicare Group plans are Medicare (MA) plans that have a contract with the Federal government. 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 will need to keep my Medicare Parts A and B. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Once I am a member of a Braven Medicare Group plan, I have the right to appeal plan decisions about payment or services if I disagree.
- I will read the Member Evidence of Coverage document from Braven Medicare Group Plans to know which rules I must follow as a member of a Braven Medicare Group plan. I understand that beginning on the date Braven Medicare Group Plans coverage begins, I must get all of my health care from Braven Medicare Group, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Braven Medicare Group and other services contained in my Braven Medicare Group Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Braven Health will pay for benefits or services that are not covered.
- I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Braven Medicare Group, he/she may be paid based on my enrollment in Braven Medicare Group. Braven Medicare Group plans that include Part D drug coverage only: 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 Railroad Retirement Board (RRB). DO NOT pay Braven Health the Part D-IRMAA.

Release of Information:

- By joining this Medicare Advantage Plan, I acknowledge that Braven Health 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. 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.
- 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 authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (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.

Your Signature: _____

Today's Date: _____

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

Name: _____

Address: _____

Phone number: _____

Relationship to enrollee: _____

Office Use Only

Name of staff member/agency/broker (if assisted in enrollment):

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Products are provided by Braven Health, an independent licensee of the Blue Cross Blue Shield Association. The Blue Cross® and Blue Shield® names and symbols are registered marks of the Blue Cross Blue Shield Association. The Braven HealthSM name and symbols are service marks of Braven Health.

© 2025 Braven Health, Three Penn Plaza East, Newark, New Jersey 07105. (0825)

H0885_ECNA0024546_C