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

Enrollment Form 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)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January1)
- 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:
MMM Healthcare, LLC.
PO BOX 71114
SAN JUAN, PR 00936-8014
Once they process your request to join, they'll contact you.

How do I get help with this form?

Call MMM at 787-620-2396, 1-833-647-9555.
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 MMM al 787-620-2396, 1-833-647-9555 / 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.

Scope of appointment number:_____ Sales agent number:_____

Please contact MMM Healthcare, LLC. (MMM), if you need information in another language or format (example: large print). This document is available in our web page www.mmmpr.com in large print for immediate access.

SECTION 1 - ALL FIELDS ON THIS PAGE ARE REQUIRED (UNLESS MARKED OPTIONAL)

To enroll in MMM, please provide the following information:

Check which plan you want to enroll in:

Plan	Contract	PBP Number	Monthly Premium
☐ MMM Balance (HMO-POS) Zona 1	H4004	073-001	$0
☐ MMM Balance (HMO-POS) Zona 2	H4004	073-002	$0
☐ MMM Balance (HMO-POS) Zona 3	H4004	073-003	$0
☐ MMM Deluxe (HMO-POS)	H4003	055	$0
☐ MMM Elite (HMO-POS)	H4003	034	$0
☐ MMM Grandioso (HMO-POS)	H4004	070	$0
☐ MMM Mega Flex (HMO-POS)	H4004	071	$0
☐ MMM Plenitud (HMO-POS)	H4004	065	$0
☐ MMM Supremo (HMO C-SNP)	H4003	009	$0
☐ MMM Único (HMO-POS)	H4003	019	$15
☐ MMM Valioso (HMO-POS)	H4004	066	$0
☐ PMC Max (HMO-POS)	H4004	056	$0
☐ MMM Combo Platino (HMO D-SNP)	H4004	068	$0
☐ MMM Diamante Platino (HMO D-SNP)	H4003	017	$0
☐ MMM Dorado Platino (HMO D-SNP)	H4003	058	$0
☐ MMM Flexi Platino (HMO D-SNP)	H4004	069	$0
☐ MMM Relax Platino (HMO D-SNP) Zona 1	H4004	072-001	$0
☐ MMM Relax Platino (HMO D-SNP) Zona 2	H4004	072-002	$0
☐ MMM Relax Platino (HMO D-SNP) Zona 3	H4004	072-003	$0
☐ PMC Premier Platino (HMO D-SNP)	H4004	048	$0

Last Name:

First Name:

Middle Initial: (Optional)

Nickname: (optional)

Date of Birth:
Month Day Year

Sex:
☐ **M**
☐ **F**

Home phone number:

Cell phone number:

Email address:

By providing your telephone number(s) and email address(es), you authorize MMM Healthcare, LLC., to contact you via manual or automated phone calls, text messages (SMS), and emails to send information related to your membership. This may include appointment or vaccination reminders, updates regarding your coverage or benefits, confirmations of requested services, renewal alerts, notifications about chronic condition management programs, care coordination, and service quality surveys.

☐ **I consent to receive manual and automated phone calls, text messages, and emails related to my health plan and medical services.**

Select if you are homeless: ☐ Yes ☐ No

Residential address Permanent Residence street address (**Don't enter a PO Box.** However, for individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:

State: P R

Zip Code:

Mailing address (PO Box allowed. Only if different from your permanent residential address):

City:

State: P R

Zip Code:

Emergency contact (optional):

Mailing address (only if different from your permanent residential address):

City:

State: P R

Zip Code:

Relationship to you:
☐ Spouse
☐ Son/Daughter
☐ Father
☐ Other

Phone number:

Cell phone number:

Email address:(optional)

Your Medicare information:

Medicare Number:

☐☐☐ - ☐☐ - ☐☐☐☐ - ☐☐☐

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Answer these important questions:

Will you have other prescription drug coverage (Like VA, TRICARE) in addition to **MMM**? ☐ Yes ☐ No

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

Group number for this coverage: _____

If you select a Special Needs Plan for Chronic Conditions (HMO C-SNP), please choose all the conditions that apply. Chronic Conditions: I understand that, as of my knowledge, I suffer of:

☐ Diabetes Mellitus ☐ Cardiovascular Disorders ☐ Congestive Heart Failure

☐ **Selection of Platino Benefit**

Medicare Platino is a coverage option provided by **MMM** with the **Federal Government and the Commonwealth of Puerto Rico** (Medicaid). The Health Services Administration has combined their benefits to offer the Medicare Platino Program for all beneficiaries enrolled in Medicaid with Medicare Parts A and B.

Are you enrolled in the State Medicaid Program? ☐ Yes ☐ No

If you answered "yes", please provide a copy of your "Notification of action taken in regards to the request and/or reevaluation of medical assistance program" (MA10 form), and provide your required Medicaid number to confirm your Medicaid coverage: _____

Previous medical coverage (Optional):

☐ Triple S ☐ Humana ☐ MCS ☐ Medicare Original ☐ Other: _____

IMPORTANT: Read and sign below:

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

Today's date:

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

_____

Beneficiary or Legal Representative signature:

MMM

If you are a Legal Representative, you must sign above and provide the following information:

Last Name:

First Name:

Address (P.O. Box allowed):

City:

State: P R

Zip Code: -

Phone number: - -

Cell phone number: - -

Relationship to beneficiary:

Email address: _____

Witness: If you are a witness, you must provide the following information and sign below:

Last Name:

First Name:

Address (P.O. Box allowed):

City:

State: P R

Zip Code: -

Phone number: - -

Cell phone number: - -

Relationship to beneficiary:

Witness Signature: _____

MMM Healthcare, LLC., is an HMO-POS plan and an HMO C-SNP plan with a Medicare contract. Enrollment in MMM depends on contract renewal. MMM Healthcare, LLC., is an HMO D-SNP plan with a Medicare contract and a contract with the Puerto Rico Medicaid program. Enrollment in MMM depends on contract renewal. MMM Healthcare, LLC., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MMM Healthcare, LLC., cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

MMM

SECTION 2 - ALL FIELDS ON THIS PAGE ARE OPTIONAL

ANSWERING THESE QUESTIONS IS YOUR CHOICE. YOU CAN'T BE DENIED COVERAGE BECAUSE YOU DON'T FILL THEM OUT.

Please, select the language in which you prefer to receive the information of your health coverage.

☐ Spanish ☐ English ☐ Other (specify): _____

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

☐ Large Print ☐ Audio CD ☐ Braille ☐ Data CD ☐ Digital format

Please contact MMM at 787-620-2397, 1-866-333-5470 (toll free) if you need information in another accessible format or language other than what is listed above. Our office hours are Monday through Sunday, from 8:00 a.m. to 8:00 p.m. TTY users (hearing impaired) can call 711.

1. Do you work? ☐ Yes ☐ No Do you have other health insurance? ☐ Yes ☐ No

   Name of other coverage: _____ ID number for this coverage: _____

   Group number for this coverage: _____ Effective Date for this coverage: _____

   RX BIN _____ RX PCN : _____

   Rx Group : _____ Rx ID: _____

2. Does your spouse work? ☐ Yes ☐ No

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

   If you answered "yes", please provide the following information:

   Name of institution: _____ Phone number: _____

   Name of contact person: _____

Please include the information of the Primary Care Provider (PCP) that you selected:

Last name: | | | | | | | | | | | | | | | | | | |

First name: | | | | | | | | | | | | | | | | | | |

Phone number: | | | | - | | | | - | | | | |

City: _____

I have received the following materials from MMM Representative, Agent or Broker. Select one or more:

☐ Pre-Enrollment Checklist ☐ Provisional Proof of Enrollment ☐ Star Rating Letter ☐ Summary of Benefits (SB)
☐ Annual Notice of Changes (if applicable) ☐ Evidence of Coverage (EOC) (includes the Privacy Notice)
☐ Notification of electronic EOC availability ☐ Drug Formulary ☐ Provider and Pharmacy Directory
☐ OTC Catalog (if applicable) ☐ Privacy Notice ☐ NOA ☐ Monthly Evidence of Benefits (EOB)
☐ Notice about Non-Discrimination

☐ **I agree and allow MMM to send me the following communications electronically:** Information about my identification card, certification of coverage, explanation of benefits for medical services, enrollment and disenrollment notices, notices of organizational determinations (such as authorization and denial letters), among other documents that I can select within the MMM mobile application and/or by calling Member Services. I understand that by signing up for the MMM mobile app or accessing https://member.innovamd.com/#/ I can get the most out of my plan's digital tools. I understand that the information included in these communications is protected health information (PHI) protected by HIPAA Law, therefore I agree that I am responsible for providing MMM with my current email address, and for notifying MMM when my email address changes or is updated. I understand that I can update my email address and/or change my delivery method preferences for theses communications at any time by calling the Member Services number included on my ID card. I understand that this consent is voluntary and that my refusal to accept it will not affect my eligibility for benefits or enrollment, payment for my medical services or coverage, or the ability to receive treatment. I understand that I may be able to continue to receive these communications in paper format for a period of time, as determined by my health plan.

☐ **I do not accept** to receive Plan communications in electronic format.

Paying your plan premium

For beneficiaries who are enrolling in a plan with premium:

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT) or by Credit Card 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 check each month.**

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 MMM the Part D-IRMAA.

Please select a premium payment option:

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefits check. (The Social Security/RRB deduction may take two months or more to begin after Social Security or the RRB approves the deduction. In most cases, if Social Security or the RRB accepts 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 the RRB does not approve your request for automatic deduction, we will send you a payment book for your monthly premiums.)
I get monthly benefits from: ☐ Social Security ☐ RRB

☐ Electronic Funds Transfer (EFT) from your bank account each month. Please enclose a copy of a VOIDED check or provide the following information:

Account holder name:

Bank routing number: Bank account number:

Account type: ☐ Checking ☐ Savings

☐ Get a payment book.

☐ If you wish to pay with a credit card please contact Member Services at 787-620-2397, 1-866-333-5470 / TTY: 711.

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.

Official Use Only: ☐ ICEP ☐ IEP ☐ AEP ☐ OEP ☐ SEP ☐ NOT ELEGIBLE

	SEP Code	Special election period affirmations (SEP)
○	MOV	During the next month I will move, or within the last two months I have moved out of the service area that my current plan serves. Date of move: _____
○	MDE	I have Medicare and Medicaid, or my State helps me with the payment of Medicare premiums.
○	LEC	I no longer meet the requirements for the coverage of my former employer or I dropped the coverage of an employer. Date of loss: _____
○	OTH	I have special needs that allow for an exception to my subscription *(MMM will evaluate your case and will contact you).*

Official Use Only:

Plan ID number: _____

Date received by Sales Representative/Agent/Independent Producer: ☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

Effective date of coverage: ☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

Sales Location:

☐ Seminar ☐ In-home/WI ☐ Mail ☐ In-office ☐ Fax
☐ UCID Telephone: ☐☐☐ - ☐☐☐ - ☐☐☐☐ ☐ Other ☐ Walk-in
☐ Institution Telephone: ☐☐☐ - ☐☐☐ - ☐☐☐☐ ☐ Institution/Home
☐ POS

Where did you find information about the plan?

☐ Newspaper ☐ Physician's office ☐ Billboard ☐ Mail
☐ Magazine ☐ MMM employee ☐ Brochure ☐ Internet
☐ Radio ☐ Friend or family referral ☐ TV ☐ Previous client
☐ MMM office ☐ Fax ☐ Other: _____

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: _____

Signature: _____

Relationship to enrollee: _____

National Producer Number (Agents/Brokers only): _____

Sales Representative/Agent/Independent Producer Name: _____

Sales Representative/Agent/Independent Producer Signature: _____

Employee/Agent/Independent Producer Number: _____

Appointment Confirmation Number: _____