2026 Individual Enrollment Application

Trinity Health Plan New York

Follow these easy steps to become a Trinity Health Plan New York member:

Confirm you live in the service area
You must live in the Trinity Health Plan New York (HMO) service area to be eligible to join our plan. Trinity Health Plan New York is currently available in select counties in New York. Visit https://www.thpmedicare.org/new-york/plans-and-benefits/service-area for a complete list of covered counties.

Have your Medicare card ready
You will need your red, white and blue Medicare card to complete the enrollment form. Fill in the information exactly as it appears on your Medicare card.

Complete, sign and date your enrollment form
Please print legibly and complete all sections of the form. Remember to sign and date your enrollment form before submitting. Complete one form per applicant.

Submit your enrollment form
Mail the white copy of your completed enrollment to:

ATTN: Enrollment
Medicare Health Plan
PO BOX 6111
Westerville, OH 43086-9874

Please make sure that all pages of the form are included. The yellow copy of the enrollment form is yours to keep for your records.

Call us if you have questions
If you have questions or need assistance with your application, you can call a licensed Trinity Health Plan New York sales agent at **1-866-679-1132** (TTY: 711).

From September 2 to March 31, we are open from 8 a.m. to 8 p.m., seven days a week. From April 1 through September 1, we are open 8 a.m. to 8 p.m. Monday through Friday. On certain holidays and weekends, your call will be handled by our automated phone system.

Have you considered applying online?

Trinity Health Plan New York online enrollment form offers a fast, secure and easy way to apply. If you would prefer to apply online, visit https://www.thpmedicare.org/new-york/enroll.

Trinity Health Plan New York (HMO) is a Medicare Advantage organization with a Medicare contract. Enrollment in Trinity Health Plan New York depends on contract renewal. Benefits vary by county. To file a grievance, call 1-800-MEDICARE to file a complaint with Medicare. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-546-2834 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 888-546-2834 (TTY: 711).

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

2026 Individual Enrollment Application

Trinity Health Plan New York

Who can use this form?
People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug 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 Sections 1-7 identified with an asterisk (*) as required information. All other information is optional — you can't be denied coverage because you didn'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:
ATTN: Enrollment
Medicare Health Plan
PO BOX 6111
Westerville, OH 43086-9874

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

How do I get help with this form?
Call Trinity Health Plan New York at 1-866-679-1132 (TTY: 711). Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Trinity Health Plan New York al 1-866-679-1132/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.

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

2026 Individual Enrollment Application

Trinity Health Plan New York

Please complete Sections 1-7. Complete one enrollment form per applicant. Asterisks (*) indicate required information. All other information is optional. Answering optional questions is your choice — you cannot be denied coverage because you did not fill them out.

Section 1: Plan Selection

Select the name of the plan you wish to join.* *(choose one)*

Plan Name	Plan Benefit Package	Monthly Premium
HMO		
☐ Trinity Health Plan New York Cash Back (HMO)[1,2]	H9827-004-000	$0 ($70 Part B Buy-Back)
☐ Trinity Health Plan New York Glory No RX (HMO)[1]	H9827-003-000	$0 ($60 Part B Buy-Back)
☐ Trinity Health Plan New York No Premium (HMO)[1]	H9827-001-000	$0 ($7 Part B Buy-Back)

Optional: Add enhanced comprehensive dental coverage[2] in addition to what is already included in your plan. If you selected an HMO plan above, you may enroll in an HMO supplemental dental plan[2]; if you selected a PPO plan above, you may enroll in a PPO supplemental dental plan.

To enroll in an Optional Supplemental Dental Plan, select the plan name below. *(choose one)*

Optional Supplemental Dental Plan Name	Monthly Premium
☐ Dental Silver	$19
☐ Dental Gold	$44

Section 2: Information About You

First Name* | **Last Name***

Middle Initial | **Date of Birth*** *(MM/DD/YYYY)* | **Sex*** ☐ **Male** ☐ **Female**

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

City* | **State*** | **ZIP*** | **County**

Mailing Address, if different from your permanent address *(PO Box allowed)*

City | **State** | **ZIP**

Phone Number* | **Email Address**

Applicant Name: *Medicare Number:*

Section 3: Primary Care Provider

Provider First Name	**Provider Last Name**

Section 4: Medicare Eligibility

Your Medicare Information

The following information can be found on your red, white and blue Medicare card. Copy the information exactly as it appears.

Your Medicare Number* (xxxx-xxx-xxxx)	**Effective Date** Hospital (Part A)*	**Effective Date** Medical (Part B)*

Select a reason for enrolling*

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am enrolling during the Annual Enrollment Period.
- ☐ I am new to Medicare.
- ☐ I had Medicare before, but I'm now turning 65.
- ☐ Between Jan. 1 and March 31: I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ Between April 1 and Dec. 31: I'm in a Medicare Advantage Plan and have had Medicare for less than 3 months. I want to make a change.
- ☐ I recently moved outside of the service area for my current plan or I recently moved and have new options available to me. I moved on (insert date) ___ / ___ / _____.
- ☐ I recently was released from incarceration. I was released on (insert date) ___ / ___ / _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) ___ / ___ / _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) ___ / ___ / _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) ___ / ___ / _____.

Applicant Name: *Medicare Number:*

Section 4, Medicare Eligibility, continued.

- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) ___ / ___ / _____.
- ☐ I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) ___ / ___ / _____.
- ☐ I recently left a PACE program on (insert date) ___ / ___ / _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) ___ / ___ / _____.
- ☐ I am leaving employer or union coverage on (insert date) ___ / ___ / _____.
- ☐ I'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare or my state and I want to choose a different plan. My enrollment in that plan started on (insert date) ___ / ___ / _____.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) ___ / ___ / _____.
- ☐ My plan is experiencing financial difficulties to such an extent that a state or territorial regulatory authority has placed the organization in receivership.
- ☐ My plan has been identified by CMS as a consistent poor performer and is identified with a low performing icon (LPI).
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- ☐ I requested Medicare information in an accessible format. I got less time to make my decision, or I didn't get it in time to make a choice before my enrollment period ended.
- ☐ None of these statements apply to me.
  Other reason: _____

Applicant Name: *Medicare Number:*

Section 5: Important Questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Trinity Health Plan New York* ☐ Yes ☐ No

Name of other coverage

Member number **Group number**

Are you enrolled in Medicaid? ☐ Yes - Medicaid Number _____ ☐ No

Do you or your spouse work? ☐ Yes ☐ No

Are you a resident of a long-term care facility? ☐ Yes ☐ No

Facility Name

Address

Phone Number **Date Entered**

Do you need information or materials in another language? ☐ Spanish ☐ Other: _____

Do you need information or materials in an alternate format? ☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

I want to get the following materials via email. *Select one or more.*
☐ Provider Directory ☐ Formulary **E-mail address:** _____

Please contact Trinity Health Plan New York Member Services at 1-800-240-3851 (TTY 711) 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., seven days a week. On certain holidays, your call will be handled by our automated phone system.

Section 6: Paying Your Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) using one of the methods mentioned below.

Select a premium payment option*

- ☐ Get a bill. (You will receive a monthly billing statement by mail)
- ☐ Pay by Electronic Funds Transfer from my bank account each month. (Trinity Health Plan New York will mail you a form with instructions on how to complete this process)[3]
- ☐ Automatically deduct my premium from my monthly Social Security benefit check.[4]
- ☐ Automatically deduct my premium from my monthly Railroad Retirement Board benefit check.[4]

Applicant Name: *Medicare Number:*

Section 6, Paying Your Premium, continued.

Part D-IRMAA If you are assessed a Part D-Income Related Monthly Adjustable Amount (IRMAA), 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 Railroad Retirement Board. Do not pay the Part D-IRMAA to Trinity Health Plan New York.

Extra Help If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, Trinity Health Plan New York will bill you for the amount that Medicare does not cover. For information about the Extra Help program, visit www.ssa.gov/medicare/part-d-extra-help.

Section 7: Signature and Authorization

Release of Information By joining this Medicare health plan, I acknowledge that Trinity Health Plan New York will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Trinity Health Plan New York will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

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

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

Applicant Name: *Medicare Number:*

Section 7, Signature and Authorization, continued.

Applicant Signature* **Today's Date***

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

First Name Last Name

Address

City State ZIP

Phone Number Relationship to enrollee

[1] To be eligible for the Cash Back benefit, you must pay your own Part B premium, meaning you don't receive Medicaid or other forms of assistance to pay your Part B premium.

[2] Trinity Health Plan New York Cash Back (HMO) is NOT eligible for the optional dental plans.

[3] Your first EFT will occur on or around the 10th of the month following the plan's receipt of this form. Any and all past due premiums (if applicable) will also be withdrawn from your account at that time.

[4] It may take two or more months for your monthly premium to begin coming out of your check. In most cases, the first deduction 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.

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.

TO BE COMPLETED BY A LICENSED SALES REPRESENTATIVE / AGENT ONLY

Licensed Sales Agent Full Name **Licensed Sales Agent NPN**

Enrollment Period

☐ AEP ☐ OEP ☐ SEP ☐ Other

Proposed Effective Date

Agent Signature **Date**