Triple-S Optimo PSHB Voluntary Enrollment Form

This form is for individuals who are not automatically enrolled in the Triple-S Optimo PSHB but want to enroll and meet the eligibility requirements.

Instructions

Please read these instructions carefully before you fill out the form on the next page. To complete the form, you will need the following items:

1. Your Medicare member ID card
2. Your Triple-S Salud member ID card

Once you have the information above, fill out the form completely. Then you send it to:

Triple-S Optimo PSHB
P.O. Box 3539
Scranton, PA 18505

Important: If there are multiple people in your household eligible, you will each need to send in your own form.

Questions

If you have any questions about this form, please call us toll-free at 833.201.9256 (TTY: 1.866.215.1999) Monday to Friday: 7:30am to 8:00pm (AST), Saturday: 9:00am to 6:00pm (AST), Sunday: 11:00am to 5:00pm (AST)

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Name and Contact Information		
First Name:	Last Name:	Middle Initial:
Birth Date:	Sex: Male ☐ Female ☐ Prefer Not to Say ☐	
Permanent U.S. Address (cannot be a PO box)		
Street Address:		
City:	State:	Zip Code:
Phone Number:	Email (Optional):	
Mailing Address (if different than permanent address above)		
Street Address:		
City:	State:	Zip Code:
Health Plan Information		
Medicare Member ID: *Get this number from your Medicare ID card.*		
Plan Name: Triple-S Optimo PSHB	PBP ID: 807	
Triple-S Member ID: *Get this from your member ID card.*		

Acknowledgement

I understand that by enrolling in the Triple-S Optimo PSHB I must keep my Medicare Part A and/or B coverage. I also know that this means that my information will be shared 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 Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D 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 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.

Signature:	Today's Date:
Authorized Representative (if applicable, sign above and fill in the fields below)	
Name:	Phone Number:
Address:	Relationship to Member:

Section 2 – All fields in this section are optional We will not deny your coverage if you choose not to answer these questions
Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.
☐ No
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, Other
☐ Prefer Not to Answer
What is your race? Select all that apply.
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian and Pacific Islander
☐ White
☐ Other
☐ Prefer Not to Answer
Requests for material in a different format
☐ Check this box if you would like materials sent to you in Spanish ☐ Check this box if you would like materials sent to you in large print