



Fax to: **(866) 819-4774**

Attn: Application Processing

Enrollment Form Cover Sheet

Enrollee's Name: _____ Submission Date: _____

Circle One: **Facility / Community Resident** Facility Name: _____

☐ Community Reference Source: _____

Agent Name: _____

Agent Phone #: _____ Agent E-mail: _____

Enrollment Form Checklist:

- | | |
|---|---|
| ☐ Plan Selection: AIP Dual Advantage | ☐ "Important Questions" Answered |
| ☐ Personal Info Entered (Ensure mailing address section is complete) | ☐ Primary Care Physician Selected (if applicable) |
| ☐ Payment Method (Circle one): | ☐ Election Period Selected |
| Direct Bill | ☐ Applicant or POA Signature |
| Social Security/Railroad Deduction | ☐ Agent Section Completed w/ proposed effective date |
| | ☐ Scope of Appointment Form (if required) |

For Plan use only

Received by Plan on: _____

Member ID #: _____

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