Health Plan Choice Form

If you do not want to automatically enroll in the Cal MediConnect plan we have chosen for you, use this form to choose a different option. For free help with this form, contact Health Care Options at 1-844-580-7272.

STEP 1: Tell us about yourself:

First Name, Last Name

Address, City

Zip Code

Date of Birth

Sex: ○ Male ○ Female

If pregnant, due date Month Day Year

STEP 2: Choose how you want your care:

If you do NOT make a choice, you will be automatically enrolled in a Cal MediConnect Plan we have chosen for you.

OPTION A

Combine my Medicare and Medi-Cal benefits in one plan.

Choose one of these Cal MediConnect Plans:

○ 800 L.A. Care *
○ 801 Health Net
○ 816 Molina Dual Options
○ 817 Care 1st
○ 818 CareMore

* To choose the plan that you have been assigned to, select the plan with the asterisk (*).

Program of the All-Inclusive Care for the Elderly (PACE):

You may qualify for PACE (see instructions). If you want to get your Medicare and Medi-Cal benefits combined in a PACE plan, fill out this option in addition to Option A or B.

If you do not qualify, you will get your care through the Option A or Option B plan that you chose above in Step 2.

OPTION B

Keep my Medicare the way it is now AND choose a Medi-Cal plan.

Choose one of these Medi-Cal Plans to get your Medi-Cal benefits:

○ 304 L.A. Care Health Plan
  □ CF Care1st Partner Plan, LLC
  □ KA KP Cal, LLC
  □ LA L.A. Care Health Plan
  □ BC Anthem Blue Cross Partners

○ 352 Health Net Comm Solutions
  □ HN Health Net Comm Solutions
  □ MO Molina Healthcare Partner

PACE Plan:

○ 052 AltaMed Senior BuenaCare

STEP 3: Read the important information on the back before you sign this form. I understand that by filling out and signing this form, I am choosing how to get my health care.

Beneficiary’s signature Date OR Authorized Representative Signature (if any) Date

Highly Confidential