CareMore
It's what we do.™

Medicare Advantage (MA) Individual Enrollment Request Form

Please contact CareMore Health Plan if you need information in another language or format (Braille).

To enroll in CareMore Health Plan, please provide the following information

Please check which plan you want to enroll in:

CareMore Breathe (HMO SNP)

❑ AZ, Maricopa County	$0 per month
❑ AZ, Pima County	$0 per month
❑ CA, Los Angeles/Orange Counties	$0 per month
❑ CA, San Bernardino County	$0 per month
❑ CA, Santa Clara County	$55 per month
❑ CA, Stanislaus County	$59 per month
❑ NV, Clark County	$0 per month

CareMore Diabetes (HMO SNP)

❑ AZ, Maricopa County	$0 per month
❑ AZ, Pima County	$0 per month
❑ CA, Santa Clara County	$55 per month
❑ CA, Stanislaus County	$59 per month
❑ NV, Clark County	$0 per month

CareMore Heart (HMO SNP)

❑ AZ, Maricopa County	$0 per month
❑ AZ, Pima County	$0 per month
❑ CA, Los Angeles/Orange Counties	$0 per month
❑ CA, San Bernardino County	$0 per month
❑ CA, Santa Clara County	$55 per month
❑ CA, Stanislaus County	$59 per month
❑ NV, Clark County	$0 per month

CareMore ESRD (HMO SNP)

❑ CA, Los Angeles/Orange Counties	$0 per month
❑ CA, San Bernardino County	$0 per month

CareMore Reliance (HMO SNP)

❑ CA, Los Angeles/Orange Counties	$0 per month
❑ CA, San Bernardino County	$0 per month

Last name:	First name:	Middle initial:	☐ Mr. ☐ Mrs. ☐ Ms.

Birth date: (MM / DD / YYYY)	Sex: ☐ M ☐ F	Home phone number: - -	Alternate phone number: - -

Permanent residence street address (P.O. Box is not allowed):

City:	County:	State:	ZIP code:

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

Street address: City: State: ZIP code:

Emergency contact:

Phone number: Relationship to you:

Email address:

Please provide your Medicare insurance information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board (RRB).

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

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: _____

Medicare claim number: _____ Sex: ___

Is entitled to: Effective date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Paying your plan premium

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or "electronic funds transfer (EFT)," each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-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 the RRB. DO NOT pay CareMore Health Plan the Part D-IRMAA.

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or "electronic funds transfer (EFT)" each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, 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 of be billed directly by Medicare or RRB. DO NOT pay CareMore Health Planthe Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at **1-800-772-1213**. TTY users should call **1-800-325-0778**. You can also apply for Extra Help online at **www.socialsecurity.gov/prescriptionhelp**.

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, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Get a bill

☐ Electronic funds transfer (EFT) from your bank account each month.
Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: _____ Bank account number: _____

Account type: ☐ Checking ☐ Savings

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

Please read and answer these important questions

1. Do you have end-stage renal disease (ESRD)? ☐ Yes ☐ No

If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis; otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to CareMore Health Plan? ☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

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

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

If "yes," please provide the following information:

Name of institution: _____

Address & phone number of institution (number and street): _____

_____

4. Are you enrolled in your state Medicaid program? ☐ Yes ☐ No

If yes, please provide your Medicaid number: _____

5. Do you or your spouse work? ☐ Yes ☐ No

6. Do you have a chronic lung disorder? ☐ Yes ☐ No

7. Do you have diabetes? ☐ Yes ☐ No

8. Do you have a cardiovascular disorder or chronic heart failure? ☐ Yes ☐ No

Please choose the name of a primary care physician (PCP):

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

☐ Spanish ☐ Braille

Please contact CareMore Health Plan at **(800) 499-2793** if you need information in another format or language than what is listed above. Our office hours are 8 a.m. - 8 p.m., 7 days a week, (October 1 – February 14, except Thanksgiving and Christmas) and Monday - Friday (except holidays) from February 15 – September 30. TTY users should call **711**.

Please read this important information

If you currently have health coverage from an employer or union, joining CareMore Health Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join CareMore Health Plan. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read and sign below

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

CareMore Health Plan is a Medicare Advantage plan and has a contract with the federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (example: October 15 – December 7 of every year), or under certain special circumstances.

CareMore Health Plan serves a specific service area. If I move out of the area that CareMore Health Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of CareMore Health Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from CareMore Health Plan when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country, except for limited coverage near the U.S. border.

I understand that beginning on the date CareMore Health Plan coverage begins, I must get all of my health care from CareMore Health Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by CareMore Health Plan and other services contained in my CareMore Health Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR CAREMORE HEALTH PLAN WILL PAY FOR THE SERVICES**.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with CareMore Health Plan, he/she may be paid based on my enrollment in CareMore Health Plan.

Release of information: By joining this Medicare health plan, I acknowledge that CareMore Health Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that CareMore Health Plan 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. 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 authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (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 from Medicare.

Signature:	**Today's date:**

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

_____

Phone number: _____ - _____ - _____

Relationship to enrollee: _____

Office use only (To be completed by Agent/Broker): **Date:** _____

Name of staff member/agent/broker (if assisted in enrollment): Rick Plata

Effective date of coverage: _____ New to PCP? ☐ Yes ☐ No

Signature of staff member/agent/broker: _____

Application received date: _____

Agent/broker number (if applicable): BKR01072

Plan ID#: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____

1. Was this an individual face-to-face appointment? ☐ Yes ☐ No

2. If this was an individual face-to-face appointment, how was a scope of appointment (SOA) collected?

   ☐ Paper ☐ Recorded call

3. Was the SOA signed on the same day as the appointment? ☐ Yes ☐ No

4. If yes, please indicate the best reason below.

   ☐ Appointment was requested at the end of the month for the following month enrollment
   ☐ Customer walk-in
   ☐ Request for individual appointment immediately following a seminar sales event
   ☐ Next day appointment
   ☐ Other _____

5. Is this a plan transfer? ☐ Yes ☐ No

6. Enrollee's current health plan: _____

7. Refer to Touch Management Program? ☐ Yes ☐ No

Attestation of Eligibility for an Enrollment Period

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 new to Medicare.
- ☐ I recently moved outside of the service area for my current plan, or I recently moved and this plan is a new option for me. I moved 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 have both Medicare and Medicaid, or my state helps pay for my Medicare premiums.
- ☐ I get Extra Help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for Extra Help paying for my Medicare prescription drugs. I stopped receiving Extra Help on (insert date) _____.
- ☐ 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 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 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) _____.

If none of these statements applies to you or you're not sure, please contact CareMore Health Plan at 1-800-499-2793 (TTY users should call 711) to see if you are eligible to enroll. We are open from 8 am. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14; and Monday through Friday (except holidays), from February 15 through September 30.

CareMore Health Plan is an HMO/HMO SNP plan with a Medicare contract. Enrollment in CareMore Health Plan depends on contract renewal.

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Medicare Advantage Plan
Statements of Understanding Checklist

These items are reminders that the sales agent must cover when selling Medicare Advantage Plans. The enrollee must check either "Yes" or "No" after the sales agent reviews each item. If "No" is checked, the sales agent must successfully review the item before the enrollee checks "Yes." Then the enrollee may place his/her initials next to the "Yes" box to indicate that the sales agent successfully reviewed the item.

QUESTION	YES	NO
1) Do you understand that you have applied for a Medicare Advantage (HMO) plan?	❑	❑
2) Do you understand the plan you have selected is not a Medicare Supplement (Medigap) plan?	❑	❑
3) Do you understand that the sales agent does not represent Medicare, Social Security, or any other government agency?	❑	❑
4) Did the sales agent explain the eligibility requirements to enroll in the desired Medicare Advantage plan?	❑	❑
5) Did the sales agent fully explain your premium, deductible, benefits, copays and coinsurances, where applicable?	❑	❑
6) Do you understand that you must use your Medicare Advantage plan ID card, and not your Medicare card?	❑	❑
7) Did the sales agent look up your doctors, including specialists in the plan's provider directory?	❑	❑
8) Do you understand that you must use in-network doctors, specialists and facilities, except in an emergency?	❑	❑
9) Do you understand that if you use out-of-network health care providers, you will likely have higher out-of-pocket costs?	❑	❑
10) Do you understand that certain services may require a referral or authorization by your Medicare Advantage plan?	❑	❑
11) Did the sales agent explain and give you plan materials in a language, if required by Medicare, that you fully understand?	❑	❑
12) Did the sales agent make it clear that unless you receive assistance, you must continue to pay your Medicare Part B premium?	❑	❑
13) Did the sales agent explain the plan's drug list, drug tiers and the Part D late enrollment penalty?	❑	❑
14) Did the sales agent explain the coverage gap, sometimes referred to the old term, "doughnut hole"?	❑	❑

AGENT: You must give a copy to the enrollee and submit a copy of this form along with the enrollment application.

QUESTION	YES	NO
15) Did the sales agent explain the timeframes when you may enroll or disenroll in Medicare Advantage plans?	❑	❑
16) Did the sales agent give you his/her contact information (name, phone or business card)?	❑	❑
17) Did the sales agent review and give you a copy of your completed enrollment form?	❑	❑
18) Did the sales agent review and give you a copy of the summary of benefits?	❑	❑
19) Did the sales agent give you a copy of the multi-language insert?	❑	❑
20) Did the sales agent explain and give you a copy of the overall plan star ratings document?	❑	❑
21) Did the sales agent answer all of your questions to your satisfaction?	❑	❑

Enrollee Statement: By signing this form, I certify that my agent has reviewed this information with me, and that the information I have supplied to the agent has been accurately recorded here.

Enrollee or Legal Representative Name Signature Date

Agent Statement: I certify that I have reviewed this document, and other Plan or CMS required information with the enrollee.

Agent Name Signature Date

AGENT: You must give a copy to the enrollee and submit a copy of this form along with the enrollment application.

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**For internal CareMore use only.*

Authorization for Use or Disclosure of Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), this organization may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

Use and Disclosure of Health Information

I hereby authorize _____ to use and

disclose health information concerning: _____
(Patient name and address)

As follows:

Health information to be used or disclosed (check only one box):*

☐ Any and all health information, other than psychotherapy notes may be released, including, but not limited to mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse brecords and/or HIV test results, if any, except as specifically provided below:

_____

OR

☐ All psychotherapy notes may be released, except as specifically provided below:

_____

This health information may be disclosed to:

CareMore, ATTN: Health Care Services, P.O. Box 277, Artesia, CA 90702-0277
(Name and address of person to use or receive the health information)

Purpose

The information may be used only for the following purposes (if you do not want to explain the purpose, write "At the request of the individual"):

☐ At my request.

OR

☐ For the following purposes: _____

Revocation

I understand that I may revoke this authorization at any time notifying this organization in writing. My revocation will not affect actions taken by this organization prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under HIPAA Privacy Rule-45 CFR Part 164, all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

Effect of Refusal to Sign Authorization

I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.

Expiration

This authorization is effective now and will remain in effect until records are sent.

Date authorization expires:_____

I understand I have a right to receive a copy of this authorization.

Format Request for Medical Records

Check the box that applies. Copies are available upon request.

☐ Hard copy **OR** ☐ Electronic copy

Signature

Signature: _____ Date:_____
(patient/authorized representative/spouse/financially responsible party)

Print patient name: _____ Patient date of birth: _____

If not signed by the patient, please indicate relationship:

☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of patient

Witness: _____ Date: _____

Note: Photocopy or facsimile of form is to be same as original.

For internal CareMore use only.

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Pre-Qualification and Continuity of Care Form

Proposed Effective Date of Coverage: _____

Member Name _____ Date _____

DOB _____ Medicare ID Number _____

Address _____

City _____ State _____ ZIP _____

Home Phone _____ Language _____

Emergency Contact _____ Phone _____

County: _____

Health Plan: ☐ Heart ☐ Breathe ☐ ESRD ☐ Diabetes ☐ Reliance

PHYSICIAN CURRENTLY TREATING THE APPLICANT FOR THE QUALIFYING DISEASE

PCP Currently Treating
Name & Phone number _____

New CareMore
PCP & Provider ID _____ New To PCP? ☐ Yes ☐ No

New CareMore
Dentist _____ New CareMore
Ophthalmologist _____

New CareMore
Podiatrist _____ Dialysis Center _____

New CareMore
Nephrologists _____

Other Treating Specialists
Name & Phone number _____

Continuity of Care

Do you currently use any of the following Durable Medical Equipment items?

☐ Walker	☐ Scooter	☐ Glucometer	_____
☐ Wheelchair	☐ Hospital Bed	☐ Nebulizer	_____
☐ Oversized wheelchair	☐ Lift	☐ Ambulatory aids	_____
☐ Electric wheelchair	☐ Oxygen	☐ Other	_____

DME Provider _____ Phone _____

Specialty _____ Services Pending _____

Are you currently on service with a home health agency? ☐ Yes ☐ No

HH Provider _____ Phone _____

Specialty _____ Services Pending _____

Clinical Qualifying Questions (CareMore Chronic Illness Plans Only)

If the answer is "Yes" to at least one of the questions, the candidate pre-qualifies for the condition.

Chronic Lung Disease

Have you been diagnosed with COPD, asthma, or emphysema?

☐ Yes ☐ No ☐ not sure (if marked "yes" indicate which) _____

Are you using oxygen daily to help you breathe?

☐ Yes ☐ No ☐ not sure

Diabetes

Have you been told by a doctor that you have diabetes (too much sugar in the blood or urine)?

☐ Yes ☐ No ☐ not sure

Have you ever been prescribed or are you taking insulin or an oral medication that is supposed to lower the sugar in your blood?

☐ Yes ☐ No ☐ not sure

End Stage Renal Disease (ESRD)

Do you have renal (kidney) disease and are currently on dialysis?

☐ Yes ☐ No ☐ not sure

Cardiovascular Disorders

Have you ever been told by a doctor that you have coronary artery disease, Poor circulation due to hardening of the arteries or poor veins?

☐ Yes ☐ No ☐ not sure

Have you ever had a heart attack or been admitted to the hospital for Angina (chest pain)?

☐ Yes ☐ No ☐ not sure

Chronic Heart Failure

Have you ever been told by a doctor that you have heart failure (weak heart)?

☐ Yes ☐ No ☐ not sure

Have you ever had problems with fluid in your lungs and swelling in your legs in the past, accompanied by shortness of breath, due to a heart problem?

☐ Yes ☐ No ☐ not sure

Current Medications

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I acknowledge that by joining the CareMore Health Plan, I am enrolling in a plan which offers special programs specifically designed to maintain or improve my health condition. I understand that I am required to make an appointment at a CareMore Care Center to get my special care plan underway. At that time, a health care provider will also verify any pre-qualifying conditions.

Enrollee Signature:_____ Date:_____

Agent/Broker Signature: _____ Date: _____

Agent/Broker Name: _____

Appointment schedule at time of enrollment? ☐ Yes ☐ No

Appointment Date:_____ Time: _____

Location: _____

Please mail your completed form to:

Rick Plata

Attention: Medicare health plans
23073 Montalvo Rd.
Moreno Valley, CA 92557

Or

Fax to: (888) 391- 0562

Enrollment questions?

Please call Rick Plata at (888) 235-8060 or email advisorrick@msn.com.

State Insurance Licenses;

CA 0F10820, AZ 965647, IA 8728857, NV 698209, OH 834369,

OR 759571, PA 596585, TX 1646235, UT 383908, WA 762700