CarePlus HEALTH PLANS

2022 Enrollment Form

Please follow these easy steps to become a CarePlus Medicare Advantage Plan member.

Have your Medicare card ready

Please print clearly and fill out the entire form, ensuring all required fields (in red) are completed. You will need to write the information exactly as it is on your Medicare card. **Each individual applying must fill out a separate form.**

Note: All **red** fields are required. Answering non-required fields is your choice. You can't be denied coverage if you do not complete them.

Sign and date the Enrollment Form

This form is not complete until you sign it. If the form is not completed and returned within the allotted time period, the enrollment could be denied. If an authorized representative fills out this form, he or she will need to sign it, and legal documentation must be provided upon request.

Please do not send duplicate Enrollment Forms for the same plan and effective date.

If you have questions, please call Member Services at **1-800-794-5907 (TTY: 711)**. From October 1 – March 31, we are open 7 days a week; 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday – Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.

Read this important information

Please read this Enrollment Form completely to ensure you understand the information provided prior to signing.

You may **mail** this Enrollment Form to:

CarePlus Enrollment Forms
P.O. Box 14733
Lexington, KY 40512-4642

or **fax** this Enrollment Form to:

1-855-819-8679

Note: A Fax Cover Sheet has been included on the back of this page for your convenience.

CarePlus HEALTH PLANS

FAX COVER SHEET

DATE: _____

TO: **CarePlus Enrollment**

FAX NO.: **1-855-819-8679**

NO. OF PAGES (Including Cover Sheet): _____

FROM (First and Last Name): _____

AGENT ID # (SAN) – if completed by an agent**:** _____

PHONE: _____

FAX NO.: _____

***** Before faxing this enrollment form, please ensure all required fields (in red) are marked and legible *****

Message: _____

_____

_____

_____

_____

_____

P.O. Box 14733 Lexington, KY 40512-4642

If you have questions, please call Member Services at **1-800-794-5907 (TTY: 711)**. From October 1 to March 31, we are open 7 days a week; 8 a.m. to 8 p.m. From April 1 to September 30, we are open Monday – Friday; 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.

IMPORTANT!

At CarePlus, it is important you are treated fairly.

CarePlus Health Plans, Inc. does not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion. Discrimination is against the law. CarePlus complies with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by CarePlus, there are ways to get help.

- You may file a complaint, also known as a grievance, with:
  CarePlus Health Plans, Inc. Attention: Member Services Department.
  11430 NW 20th Street, Suite 300. Miami, FL 33172.
  If you need help filing a grievance, call **1-800-794-5907 (TTY: 711)**. From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Auxiliary aids and services, free of charge, are available to you. 1-800-794-5907 (TTY: 711).

CarePlus provides free auxiliary aids and services, such as qualified sign language interpreters and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you.
1-800-794-5907 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
ગુજરાતી (Gujarati): નઃશૂલ્ક ભાષા સહાય સેવાઓ પ્રરાપ્ત કરવા માટે ઉપરોક્ત નંબર પર કૉલ કરો.
ภาษาไทย (Thai): โทรติดต่อที่หมายเลขด้านบนนี้เพื่อรับบริการช่วยเหลือด้านภาษาโดยไม่เสียค่าใช้จ่าย.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.
العربية (Arabic): الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

CP REV: 6.25.20

All Red Fields Are Required **Proposed Effective Date (insert month): _____ / 01 / 2022**

Please contact CarePlus Health Plans if you need information in another language or format.

To enroll in CarePlus, please provide the following information:

Plan selection

Please Select Only One:

- ☐ CareOne (HMO)
- ☐ CareOne PLUS (HMO)
- ☐ CareOne PLUS (HMO-POS)
- ☐ CareFree (HMO)
- ☐ CareFree PLUS (HMO)
- ☐ CareExtra (HMO)
- ☐ CareOne PLATINUM (HMO)
- ☐ CareOne PLATINUM (HMO-POS)
- ☐ CareComplete (HMO C-SNP)
- ☐ CareSalute (HMO)
- ☐ CareBreeze (HMO C-SNP)
- ☐ CareNeeds PLUS (HMO D-SNP)*

*Applicable Medicaid eligibility required

Please provide your Medicare insurance information:

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

-OR-

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

MEDICARE HEALTH INSURANCE

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

Is Entitled To:	Effective Date:
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

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

Member ID (For current or past CarePlus members)**:** _____

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Birth Date: _____ (MM/DD/YYYY) **Sex:** _____

It is important that we are able to reach you with the information you need to stay informed and take care of your health. Please provide your email address and telephone number.

Email Address: _____

By providing your email address, you authorize CarePlus to send you health information to this address.

Phone Number: _____ ☐ Home ☐ Cell ☐ Work ☐ Other

Alternate Phone Number: _____ ☐ Home ☐ Cell ☐ Work ☐ Other

There may be times when CarePlus will use an automated system to call or text you. When that happens, we will be sure to use the telephone number you provided.

Permanent Residence (your residential address is required to confirm your service area):

Street Address: _____

City: _____ **County:** _____ **State:** _____ **ZIP Code:** _____

Mailing Address (if different from your Permanent Residence Address):

Street Address: _____

City: _____ State: _____ ZIP Code: _____

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Please choose a Primary Care Physician (PCP), clinic or health center:

PCP Name (print): _____ **PCP ID #:** _____

Are you already a patient of the PCP you chose? ☐ Yes ☐ No

Paying your plan premium

If you have selected a plan with zero monthly premium and 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 having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you have selected a plan with a monthly premium, you can pay this premium (including any late enrollment penalty that you currently have or may owe) by mail or EFT each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or RRB benefit check each month.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). **DO NOT pay CarePlus the Part D-IRMAA.**

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

Please select a premium payment option:

☐ Automatic deduction from your monthly Social Security or RRB benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(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.)

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

I hereby authorize CarePlus to initiate debit/credit entries to my checking/savings account for payment of premium.
☐ Checking ☐ Savings

Account Holder Name: _____

Depository Bank Name: _____

BANK ROUTING NUMBER ☐☐☐☐☐☐☐☐☐

BANK ACCOUNT NUMBER ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐ Get a monthly bill

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Please read and answer these important questions:

1. **Once enrolled, will you have other medical health coverage?** ☐ Yes ☐ No
   If yes, complete the following:
   Carrier Name: _____
   Carrier Address 1: _____ Carrier Address 2: _____
   City: _____ State: _____ Zip: _____
   Group Number: _____ ID Number: _____
   Are you the primary policy holder? ☐ Yes ☐ No
   Effective date of coverage: _____ Phone: _____ (###) ###-####

2. **If you will have other prescription drug coverage (like VA, TRICARE) in addition to this plan for which you are applying, please check this box.** ☐ I will have other prescription drug coverage.
   Please provide your other prescription drug coverage details here, if applicable.
   Name of other coverage: _____ Phone : _____ (###) ###-####
   ID # for this coverage: _____ Group # for this coverage: _____

3. Are you enrolled in your State Medicaid Program? ☐ Yes ☐ No
   If yes, please provide your Medicaid number: _____
   *Applicable Medicaid eligibility is required when enrolling in a CareNeeds PLUS plan

4. If you are enrolling in CareComplete (HMO C-SNP), have you been diagnosed and are currently being treated for Diabetes, Cardiovascular Disorder, and/or Chronic Heart Failure? ☐ Yes ☐ No

5. If you are enrolling in CareBreeze (HMO C-SNP), have you been diagnosed and are currently being treated for Chronic Lung Disorder? ☐ Yes ☐ No

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

7. Please select one of the language preferences below:
   ☐ English ☐ Spanish ☐ Other: _____

8. If you need information in an accessible format, please select one of the options below:
   ☐ Audio ☐ Large Print ☐ Accessible Screen Reader PDF ☐ Oral Over the Phone ☐ Braille

   Please contact Member Services at **1-800-794-5907 (TTY: 711)** if you need information in an accessible format or language other than what is listed above.

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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 mark the bubble if the statement(s) applies to you. By marking any of the following bubbles 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.

	Code	Enrollment Period Statements
◯	NEW	I just became eligible for Medicare Part A and/or Part B (ICEP/IEP).
◯	LEC	I am leaving employer or union coverage on (insert date) _____.
◯	AEP	I am enrolling during the Annual Enrollment Period.
◯	CHR	I am enrolling in a Chronic Care Special Needs Plan (C-SNP) that tailors its benefits to my chronic condition **OR** I was found to not have the qualifying condition after enrolling in a C-SNP and need to enroll in a different plan.
◯	CIE	I was enrolled in a plan by Medicare (or my state) within the last 3 months and I want to choose a different plan.
◯	DST	I was affected by a Federal Emergency Management Agency (FEMA) declared emergency/disaster or a disaster or other emergency declaration issued by a federal, state or local government entity, and was unable to use another election period available to me due to it.
◯	EXC	I 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) within the last 3 months.
◯	EXT	I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change. **Note: Only valid once per calendar quarter from January 1 through September 30.**
◯	INC	I was released from incarceration within the last 3 months.
◯	LAW	I obtained lawful presence status in the United States within the last 3 months.
◯	LOC	I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____. **Note: For Medicare Advantage Prescription Drug (MA-PD) plans only.**

Continued on next page

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	Code	Enrollment Period Statements
⬭	LTC	I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home). I moved/will move into/out of the facility on (insert date) _____.
⬭	MCC	I had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) within the last 3 months.
⬭	MCD	I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums), but I haven't had a change. **Note: Only valid once per calendar quarter from January 1 through September 30.**
⬭	MOV	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) _____.
⬭	NON	My existing Medicare Advantage plan is non-renewing for the upcoming contract year. **Note: Only valid from December 8th through the last day of February of the following year.**
⬭	OEP	I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period.
⬭	PAC	I left a PACE (Program of All-Inclusive Care for the Elderly) program within the last 2 months.
⬭	RUS	I returned to the United States after living permanently outside of the U.S. within the last 3 months.
⬭	SNP	I am being disenrolled from a Special Needs Plan (SNP) because I no longer have special needs status **OR** I have been disenrolled from a SNP plan within the last 3 months.
⬭	SPA	I belong to a pharmacy assistance program provided by my state. **Note: For Medicare Advantage Prescription Drug (MA-PD) plans only.**
⬭	OTH	None of the above statements apply to me; however, I feel I have a special circumstance which would allow me an exception to enroll (subject to approval). Please explain: _____ _____

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PLEASE READ THIS IMPORTANT INFORMATION:

If you currently have health coverage from an employer or union, joining CarePlus could affect your employer or union health benefits. You could lose your employer or union health coverage if you join CarePlus.

Please read and sign on the following page:

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

- I must keep both Medicare Hospital (Part A) and Medical (Part B) to stay in CarePlus.
- 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. 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.
- This CarePlus plan serves a specific service area. If I move out of the area that CarePlus serves, I need to notify the plan so I can disenroll and find a new plan in my new area. 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 when my CarePlus coverage begins, I must get all my medical and prescription drug benefits from CarePlus. Benefits and services provided by CarePlus and contained in my CarePlus "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CarePlus will pay for benefits or services that are not covered. I will abide by the rules of my Evidence of Coverage. Once I am a member of CarePlus, I have the right to appeal plan decisions about payment or services if I disagree.
- 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.

Release of Information: By joining this Medicare Advantage plan, I acknowledge that CarePlus will share my information with Medicare, who may use it to track enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).

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.**

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I have read and understand the important information on the preceding pages. I have reviewed and received a copy of the Summary of Benefits.

Your Signature: _____ Today's Date: _____

I understand that my signature (or the signature of the individual legally authorized to act on my behalf) on this enrollment form means that I have read and understand the contents of this enrollment form. If signed by an authorized representative (as described above), this signature certifies that: 1) this individual is authorized under State law to complete this enrollment, and 2) documentation of this authority is available upon request by Medicare.

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

Last Name: _____ First Name: _____

Relationship to Enrollee: _____ Phone Number: _____

Address: _____

**** Please note that valid legal documentation of this authority is required to make healthcare decisions or inquiries concerning the enrollee. ****

To be completed by a CarePlus licensed sales agent:

Sales Agent Name (Print): _____

Sales Agent Signature: _____

Sales Agent Email Address: _____

Sales Agent ID # (SAN): _____ **Date:** _____

Referring Agent Name: _____ Referring Agent #: _____

ASK THE APPLICANT: Would you like to provide your Veteran status?
☐ Self ☐ Spouse ☐ Dependent ☐ I am not a Veteran ☐ Prefers not to answer

Lead Source:
☐ Book of Business ☐ Event ☐ Marketing/Advertisement ☐ Third-Party ☐ CarePlus

Scope of Appointment ID #: _____

Agents, please select one of the below indicating the appointment type:

☐ **F2F** – Face-to-Face
☐ **TEL** – Telephonic
☐ **RET** – Retail Partner
☐ **GCS** – Guidance Center Seminar (no SOA required)
☐ **INH** – In-Home Appointment
☐ **OTH** – Other
☐ **GCW** – Guidance Center Walk-in
☐ **SEM** – Seminar (no SOA required)
☐ **WAL** – Walmart (no SOA required)

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