CarePlus HEALTH PLANS

2023 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. Write the information exactly as it is on your Medicare card. **Each individual who applies must fill out a separate form.**

Note: All **red** fields are required. Non-required fields are optional. 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 you do not complete and return this form on time, we may have to deny your enrollment. If someone is authorized to complete this form for you, he or she must sign it. This person must provide their legal proof of authorization if requested.

Please do not send multiple 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

Before you sign, please read this entire Enrollment Form to make sure you understand the information provided.

Individuals experiencing homelessness: If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

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

CarePlus Enrollment Forms
PO Box 14733
Lexington, KY 40512-4642

or **fax** this Enrollment Form to: **1-855-819-8679**

Note: Please use the Fax Cover Sheet on the back of this page.

CarePlus HEALTH PLANS

FAX COVER SHEET

Date: _____

To: **CarePlus Enrollment**

Fax Number: **1-855-819-8679**

Number of Pages (Including Cover Sheet): _____

From (First and Last Name): _____

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

Phone: _____

Fax Number: _____

***** Before you fax this Enrollment Form, please make sure all required fields (in red) are completed clearly and legibly *****

Message: _____

_____

_____

_____

_____

_____

THIS FACSIMILE CONTAINS PRIVILEGED AND CONFIDENTIAL INFORMATION INTENDED ONLY FOR THE USE OF THE ADDRESSEE(S) NAMED ABOVE. IF YOU ARE NOT THE INTENDED RECIPIENT OF THIS FACSIMILE OR IF THE EMPLOYEE OR AGENT RESPONSIBLE FOR DELIVERING IT TO THE INTENDED RECIPIENT, YOU ARE NOTIFIED THAT ANY DISSEMINATION OR COPYING OF THIS FACSIMILE IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS FACSIMILE IN ERROR, PLEASE NOTIFY US BY TELEPHONE AND RETURN THE FACSIMILE TO US AT THE BELOW ADDRESS BY MAIL.

PO Box 14733 Lexington, KY 40512-4642

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 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, ethnicity, marital status, religion, or language. 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: Grievances and Appeals department.
  PO Box 277810, Miramar, FL 33027.
  If you need help filing a grievance, call Member Services at **1-800-794-5907 (TTY: 711)**. October 1 - March 31, 7 days a week, 8 a.m. to 8 p.m. April 1 - September 30, Monday - Friday, 8 a.m. to 8 p.m. You may 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 their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or 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.

CarePlus HEALTH PLANS

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-794-5907 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-794-5907 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-794-5907 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-794-5907 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-794-5907 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-794-5907 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-794-5907 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-794-5907 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고있습니다 . 통역 서비스를 이용하려면 전화 1-800-794-5907 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-794-5907 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (برقياً: 711) 1-800-794-5907. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه هي خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके कसिी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषयिा सेवाएँ उपलब्ध हैं. एक दुभाषयिा प्राप्त करने के लिए, बस हमें 1-800-794-5907 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हदिी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-794-5907 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-794-5907 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-794-5907 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-794-5907 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康健康保険と薬品処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-794-5907 (TTY: 711) にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

CP REV 7.14.22

All Red Fields Are Required **Proposed Effective Date (insert month): _____ / 01 / 2023**

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

Plan selection (please note all plans are not available in all markets)

Please Select Only One:

- ☐ CareOne Plus (HMO)
- ☐ CareOne Plus (HMO-POS)
- ☐ CareFree (HMO)
- ☐ CareFree Platinum (HMO)
- ☐ CareOne Platinum (HMO)
- ☐ CareOne Platinum (HMO-POS)
- ☐ CareComplete (HMO C-SNP)**
- ☐ CareComplete Platinum (HMO C-SNP)**
- ☐ CareComplete Platinum (HMO-POS C-SNP)**
- ☐ CareBreeze (HMO C-SNP)**
- ☐ CareBreeze Platinum (HMO C-SNP)**
- ☐ CareBreeze Platinum (HMO-POS C-SNP)**
- ☐ CareSalute (HMO)
- ☐ CareSalute (HMO-POS)
- ☐ CareNeeds Plus (HMO D-SNP)*

*Applicable Medicaid eligibility required ** Qualifying chronic condition(s) 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 (P.O. Box ONLY allowed if experiencing homelessness)

Street Address: _____

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

Mailing Address (if different from your Permanent Residence)

Street Address: _____

City: _____ State: _____ ZIP Code: _____

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

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

Are you already a patient of this PCP? ☐ Yes ☐ No

Paying your plan premium

If you selected a $0 premium plan and you owe a late enrollment penalty, 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 selected a plan with a monthly premium, you can pay this premium (and any late enrollment penalty) by mail or EFT each month. You can also 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), the Social Security Administration will notify you. 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

NOTE: Due to processing timelines required by Medicare, your Social Security or RRB deduction may be denied for your first premium payment. CarePlus will send you a paper bill for the initial payment and resubmit your request to Medicare for Social Security or RRB deduction to begin with your second month's premium. The deduction may take two or more benefit checks to begin. In most cases, if the SSA or RRB accepts your request for automatic deduction, the first deduction from your benefit check will start with the month that the SSA accepts your request. If the SSA 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 authorize CarePlus to process premium payments (and any late enrollment penalty) from the following account.
☐ Checking ☐ Savings

Account Holder Name: _____

Depository Bank Name: _____

BANK ROUTING NUMBER ☐☐☐☐☐☐☐☐☐

BANK ACCOUNT NUMBER ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐ Get a monthly bill

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 Code: _____
   Group # for this coverage: _____ ID # for this coverage: _____
   Are you the primary policy holder? ☐ Yes ☐ No
   Effective date of coverage: _____ Phone: _____

2. **If you will have other prescription drug coverage (like VA or TRICARE) in addition to this plan, 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 (HMO D-SNP) plan

4. If you are enrolling in CareComplete (HMO C-SNP), CareComplete Platinum (HMO C-SNP) or CareComplete Platinum (HMO-POS 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), CareBreeze Platinum (HMO C-SNP) or CareBreeze Platinum (HMO-POS 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.

9. Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.
   ☐ No, not of Hispanic, Latino/a, or Spanish origin ☐ Yes, Mexican, Mexican American, Chicano/a
   ☐ Yes, Puerto Rican ☐ Yes, Cuban
   ☐ Yes, another Hispanic, Latino/a, or Spanish origin ☐ I choose not to answer

10. What's your race? Select all that apply.
    ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese
    ☐ Filipino ☐ Guamanian or Chamarro ☐ Japanese ☐ Korean ☐ Native Hawaiian
    ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White
    ☐ I choose not to answer

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 an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster. **Election Period Missed:** _____ **Emergency/Disaster Experienced:** _____
◯	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.

Continued on next page

	Code	Enrollment Period Statements
⬭	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.**
⬭	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.
⬭	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: _____ _____ _____ _____

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 understand that I can be enrolled in only one Medicare Advantage (MA) or Part D plan at a time - and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS and MA MSA plans).
- 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 CarePlus so I can disenroll and find a new plan.
- I understand that individuals 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.**

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 we require valid legal documentation of this authority to make healthcare decisions or inquiries concerning the enrollee. ****

For internal use 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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