



Individual Enrollment Request Form

Please contact CareMore Health Plan if you need information in another language or format (Braille). To Enroll in StartSmart with CareMore HMO, please provide the following information.

Please check which plan you want to enroll in:

- | | | |
|--|---------------|-------------------------------|
| <input type="checkbox"/> AZ, Maricopa/Pinal County | \$0 per month | \$40 Monthly Part B Reduction |
| <input type="checkbox"/> CA, Los Angeles/Orange County | \$0 per month | \$75 Monthly Part B Reduction |
| <input type="checkbox"/> CA, Riverside County | \$0 per month | \$40 Monthly Part B Reduction |
| <input type="checkbox"/> CA, San Bernardino County | \$0 per month | \$40 Monthly Part B Reduction |
| <input type="checkbox"/> CA, Santa Clara County | \$0 per month | \$0 Monthly Part B Reduction |
| <input type="checkbox"/> CA, Stanislaus County | \$0 per month | \$0 Monthly Part B Reduction |
| <input type="checkbox"/> NV, Clark County | \$0 per month | \$40 Monthly Part B Reduction |


Last Name		First Name		M.I.	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth date (Mo/Day/Yr)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number		Alternate Phone Number	
Permanent Residence Street Address (P.O. Box is not allowed)			City	State	Zip Code
Mailing Address (only if different from your Permanent Residence Address)			City	State	Zip Code
Emergency Contact			Phone Number	Relationship to you	
Email Address					
Have you moved during this calendar year? <input type="checkbox"/> YES <input type="checkbox"/> NO Date of move _____/_____/_____					
Personal Physician Choice / Name and I.D. Number _____				Existing Patient <input type="checkbox"/> YES <input type="checkbox"/> NO	
Dentist Choice / Name and I.D. Number (if applicable to your plan) _____					

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.

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, "Electronic Funds Transfer (EFT)" or a credit card, each month or quarterly. 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 (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.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% of drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. 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 (if applicable):

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: _____ Account type: Checking Saving

Bank routing number: _____ Bank account number: _____

Credit Card. Please provide the following information:

Type of Card: _____ Name of Account holder as it appears on card: _____

Account number: _____ Expiration Date: ____/____ (MM/YYYY)

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 any more, 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# for this coverage: _____ Group# 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

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in a different 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 Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. TTY users should call (800) 577-5586.

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

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, including the "Statement of Understanding" on the back of this form.** 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 by Medicare.

Enrollee's 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 _____

**If you are returning this form by mail, please mail it to:
12900 Park Plaza Drive, Suite 150 Cerritos, CA 90703.**

Office Use Only:

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

Agent/Broker Number (if applicable): _____

Date Received by Plan: _____ Plan ID#: _____ Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Statement of Understanding

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 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.

I understand that if I do not elect to enroll with the optional Supplemental Dental Plan at the time of enrollment, I have 60 days from my effective date with CareMore Health Plan to make a decision to enroll or I may enroll during my annual election period. If I purchase the optional Supplemental Dental Plan, I understand payment must be made directly to the dental carrier.