Clear Spring Health Enrollment Form Instructions VIRGINIA

Clear Spring Health Essential (PPO)	**H2020-002** Chesterfield, Colonial Heights, Hanover, Henrico, Hopewell City, Petersburg City, Richmond City
Clear Spring Health Essential (HMO)	**H8293-01** Alleghany, Amelia, Appomattox, Augusta, Bath, Buena Vista City, Caroline, Charles City, Chesterfield, Clarke, Colonial Heights City, Covington City, Craig, Cumberland, Danville City, Dinwiddie, Emporia City, Essex, Franklin, Galax City, Giles, Gloucester, Goochland, Greene, Greensville, Halifax, Hanover, Harrisonburg City, Henrico, Highland, Hopewell City, Isle of Wight, King of Queen, King William, Lexington City, Lunenburg, Madison, Mathews, Mecklenburg, Montgomery, Nelson, New Kent, Nottoway, Petersburg City, Pittsylvania, Poquoson City, Powhatan, Prince George, Pulaski, Radford City, Rappahannock, Richmond, Richmond City, Roanoke, Roanoke City, Rockbridge, Rockingham, Salem City, Southampton, Staunton City, Surry, Sussex, Warren, Waynesboro City

Need Help to Enroll?

- **Contact your local sales agent** to help you choose the best plan for you and complete this individual enrollment form, or
- **Enroll online** at www.clearspringhealthcare.com
- **Call Clear Spring Health** to assist you with any questions you might have: **Toll-free: 877-384-1241 (TTY: 711).**
- **You may also complete the enrollment form, sign and date it, and mail or fax the enrollment copy to:**

  Clear Spring Health
  P.O. Box 3206
  Scranton, PA 18505

  Fax 855-382-6679

Our call center is open from
8:00 am to 8:00 pm,
Monday through Friday
from April 1 through September 30 and
8:00 am to 8:00 pm,
Monday through Sunday
from October 1 through March 31.

You may leave a voicemail Saturday,
Sunday and Federal Holidays.

Instructions to complete the enrollment form for:

Clear Spring Health Essential (PPO) **Clear Spring Health Essential (HMO)**

Please **PRINT NEATLY** on the entire form.

Please check which plan you want to enroll in then fill out the remainder of the form.

SECTION 1 INFORMATION ABOUT YOU

This section tells us basic information about you such as your name, address, and phone number. All fields are required. Please print neatly.

SECTION 2 MEDICARE INFORMATION

Please enter your Medicare information.

SECTION 3 PAYING YOUR PLAN PREMIUM and/or LATE ENROLLMENT PENALTY

If you are required to pay a premium and/or required to pay the Part D Late Enrollment Penalty, you will need to read this section carefully and select how you would like our Plan to collect this premium. Select only one: Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check OR get a bill monthly.

SECTION 4 PLEASE READ AND ANSWER THESE QUESTIONS

1. Check 'YES' or 'NO' if you have a special kidney disease called End Stage Renal Disease (ESRD).
2. Check 'YES' or 'NO' if you or your spouse are covered under another private insurance plan.
3. Check 'YES' or 'NO' if you are a resident in a long-term care facility, such as a nursing home. (If YES, please provide the name, address and phone number of the long-term care facility.)
4. Check 'YES' or NO' if you are enrolled in Medicaid. If yes please provide the Medicaid number.
5. Check 'YES' or 'NO' if you or your spouse work.

SECTION 5 SELECT A PRIMARY CARE PHYSICIAN

Please write the name of the Primary Care Physician (PCP) that you want to choose in this section. The PCP must be in our network. You must give us as much information about the PCP as you can, such as the doctor's first and last name and if he/she belongs to a group or practice, if applicable. For example: (Doctor's Name): John Q. Smith M.D. (Group/Practice Name): Greater Medical Associates.

STATEMENTS OF UNDERSTANDING

This portion of the form requires you to read several Statements of Understanding at the end of this form to be sure that you understand the terms of participating in our Plan. You must read and understand those statements.

AUTHORIZATION

Then sign your name and fill in today's date in this section. If you cannot sign and you have an authorized representative fill out this enrollment form on your behalf, then he/she must sign and date where indicated. Documentation of the authority to act on your behalf must be made available upon request by Clear Spring Health or Medicare.

If anyone helped you fill out this enrollment form, such as a sales representative or community leader, then he/she must sign and date the form, and specify his/her relationship to you.

IMPORTANT REMINDERS

- You may include a **copy** of your MEDICARE HEALTH INSURANCE identification card.
- IF APPLICABLE, attach a copy of medical notes indicating that you do not need regular dialysis anymore or that you had a successful kidney transplant.
- IF APPLICABLE, attach a copy of the legal representative's proof of authorization by state law if someone signs on behalf of the applicant.

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

This section of the form requires you to select an enrollment period that explains why you are entitled to enroll at this time. If you are enrolling during the annual election period, then you will select the first option, "I am making my annual enrollment period election (October 15 – December 7). If enrolling any time from December 8 – October 14, you will need to select one of the other options describing your specific circumstance, which will qualify you to enroll outside of the annual enrollment period.

Clear Spring Health

Clear Spring Health Application VIRGINIA

Please contact Clear Spring Health if you need information in Spanish or another format (Braille, audio tape, large print).

To Enroll in Clear Spring Health, Please Provide the Following Information:

Please check which plan you want to enroll in:

☐ Clear Spring Health Essential (PPO) $0.00 per month

☐ Clear Spring Health Essential (HMO) $0.00 per month

LAST name:	FIRST name:	MIDDLE Initial:	Mr. Mrs. Ms.

Birth Date:	Sex:	Home Phone Number:( ) -
__ __ - - __ __ __ __ (M M - D D - Y Y Y Y)	M F	Mobile Phone Number: ( ) -

Permanent Residence Street Address (P.O. Box is not allowed):
Street Address: ☐ ☐

City:	County:	State:	ZIP Code:

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

City:	County:	State:	ZIP Code:

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.

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 Part B to join a Medicare Advantage plan.

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, 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 Clear Spring Health 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.

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 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.

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 ☐ Saving

☐ **Automatic deduction** from your monthly Social Security or Railroad Retirement Board (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.)

Please choose the name of a Primary Care Physician (PCP), clinic or health center (HMO Only):

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 Clear Spring Health Essential HMO or Clear Spring Health Essential Plus HMO? ☐ 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 of Institution (number and street):_____

   Phone Number of Institution

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 another format:

☐ **Language:** Spanish

☐ **Format:** Braille, audio tape, or large print

Please contact Clear Spring Health at 877-384-1241 if you need information in another format or language than what is listed above. Our call center is open from 8:00 am to 8:00pm, Monday through Friday from April 1 through September 30 and 8:00 am to 8:00 pm, Monday through Sunday from October 1 through March 31. You may leave a voicemail Saturday, Sunday and Federal Holidays. TTY users should call 711.

—STOP—

Please Read This Important Information

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

Clear Spring Health 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.

Clear Spring Health serves a specific service area. If I move out of the area that Clear Spring Health 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 Clear Spring Health, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Clear Spring Health 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 Clear Spring Health coverage begins, I must get all of my health care from Clear Spring Health, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Clear Spring Health and other services contained in my Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR CLEAR SPRING HEALTH 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 Clear Spring Health, he/she may be paid based on my enrollment in Clear Spring Health.

Release of Information: By joining this Medicare health plan, I acknowledge that Clear Spring Health will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Clear Spring Health 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:

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

_____

Agent/Broker writing number: _____

Plan ID #: _____

Effective Date of Coverage: - - __ __ __ ____
(M M - D D - Y Y Y Y)

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

Clear Spring Health is an HMO and PPO plan with a Medicare contract. Enrollment in Clear Spring Health depends on contract renewal.
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