PRE-ENROLLMENT CHECKLIST

Clear Spring Health

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-877-364-4566 (TTY: 711)

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.clearspringhealthcare.com or call 1-877-364-4566 (TTY: 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025.
- ☐ For HMO plan enrollees: Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ For PPO plan enrollees: Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.
- ☐ For C-SNP plan enrollees: This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition

Clear Spring Health has a contract with Medicare to offer HMO, PPO, and PDP Plans. Enrollment in these plans is dependent on annual contract renewal with the federal government.

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Clear Spring Health

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 am enrolling during the Annual Enrollment Period (AEP).	
☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).	
☐ 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)	**Month** **Date** **Year**
☐ I recently was released from incarceration. I was released on (insert date)	**Month** **Date** **Year**
☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date)	**Month** **Date** **Year**
☐ I recently obtained lawful presence status in the United States. I got this status on (insert date)	**Month** **Date** **Year**
☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date)	**Month** **Date** **Year**
☐ I recently 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) on (insert date)	**Month** **Date** **Year**
☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.	
☐ 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)	**Month** **Date** **Year**

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

☐ I recently left a PACE program on (insert date)	**Month**	**Date**	**Year**
☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date)	**Month**	**Date**	**Year**
☐ I am leaving employer or union coverage on (insert date)	**Month**	**Date**	**Year**
☐ 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.	**Month**	**Date**	**Year**
☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date)	**Month**	**Date**	**Year**
☐ 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)	**Month**	**Date**	**Year**
☐ 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 natural disaster.			
☐ (C-SNP Only) I have a chronic condition that qualifies me for the chronic condition special needs plan.			

If none of these statements applies to you or you're not sure, please contact Clear Spring Health at 1-877-364-4566 (TTY users should call 711) to see if you are eligible to enroll. We are open October 1–March 31, seven days a week, 8:00 a.m.– 8:00 p.m. and from April 1–September 30, Monday through Friday, 8:00 a.m.– 8:00 p.m. (you may leave a voicemail Saturday, Sunday, and Federal Holidays).

ATENCIÓN: Si habla español tiene a su disposición servicios gratuitos de asistencia linguistica. Llame al 1-877-364-4566 (TTY: 711).

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Beneficiary First Name	**Beneficiary Last Name**

2025 MEDICARE ADVANTAGE INDIVIDUAL ENROLLMENT REQUEST FORM: SNP

OMB No. 0938-1378 | Expires: 06/30/2026

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Who Can Use This Form?

People with Medicare who want to join a Medicare Advantage plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important:

To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

What Happens Next?

Mail your completed and signed form to:
Clear Spring Health
PO Box 278530
Miramar, FL 33027

Fax your completed and signed form to:
1-866-341-2265
Attn: Clear Spring Health
Enrollment Dept.

Enroll online at:
www.clearspringhealthcare.com

Once we process your request to join, we'll contact you by mail.

When Do I Use This Form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

How Do I Get Help With This Form?

Call Clear Spring Health at 1-877-364-4566. TTY users can call 711. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Clear Spring Health al 1-877-364-4566/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

What Do I Need To Complete This Form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note:

You must complete all items in Section 1.
The items in Section 2 are optional—you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

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.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

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SECTION 1: To enroll in a Clear Spring Health Plan, please provide the following information. All fields on this page are required (unless marked optional).

Please refer to the service chart below before completing.
Select the plan you want to join.

For Medicare Beneficiaries Living With Diabetes, Cardiovascular Disorders Or Chronic Heart Failure - Chronic Condition Special Needs Plan (C-SNP)

GEORGIA

☐ **Clear Spring Health Silver (HMO C-SNP)**
$0 premium per month (H6672-003)

COLORADO

☐ **Clear Spring Health Essential (HMO C-SNP)**
$0 premium per month (H6379-002)

ILLINOIS

☐ **Clear Spring Health Essential (HMO C-SNP)**
$0 premium per month (H5454-005)

☐ **Clear Spring Health Essential (HMO C-SNP)**
$0 premium per month (H5454-006)

Plans and Monthly Premium Costs	Service Counties
GEORGIA	
Clear Spring Health Silver (HMO C-SNP) $0 per month (H6672-003)	Baker, Baldwin, Banks, Barrow, Bibb, Bleckley, Bryan, Butts, Chatham, Cherokee, Clayton, Clinch, Crawford, Dawson, DeKalb, Dodge, Dooly, Fayette, Forsyth, Franklin, Greene, Hancock, Hart, Heard, Henry, Houston, Jasper, Jones, Lamar, Lumpkin, Macon, Madison, McIntosh, Meriwether, Monroe, Morgan, Newton, Oconee, Oglethorpe, Peach, Pickens, Pike, Pulaski, Putnam, Rabun, Rockdale, Schley, Screven, Stephens, Talbot, Taliaferro, Taylor, Twiggs, Walton, White, Wilcox, Wilkinson
COLORADO	
Clear Spring Health Essential Plan (HMO C-SNP) $0 per month (H6379-002)	Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Crowley, Custer, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Grand, Huerfano, Jackson, Jefferson, Larimer, Morgan, Park, Pueblo, Teller, Washington, Weld
ILLINOIS	
Clear Spring Health Essential Plan (HMO C-SNP) $0 per month (H5454-005)	Boone, Clinton, Macoupin, Madison, Ogle, St. Clair, Stephenson, Winnebago
Clear Spring Health Essential Plan (HMO C-SNP) $0 per month (H5454-006)	Cook, DuPage, Kane, Kankakee, LaSalle, McHenry, Will

* Your costs may be as low as $0, depending upon your level of Medicaid eligibility.

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SECTION 1 (continued)

First Name	Last Name	Optional: Middle Initial

Birthdate (mm/dd/yyyy)	Sex ☐ Male ☐ Female
Primary Phone Number	Alternate Phone Number (optional)

Email Address (optional)

Permanent Residence Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.)

Address 2

City	State	Zip Code

Mailing Address (only if different from your Permanent Address. P.O. Box allowed)

Address 2

City	State	Zip Code

Emergency Contact Information Below is Optional

Emergency Contact

Emergency Contact Phone Number	Relationship to You

Your Medicare Information

Medicare Number ☐☐☐☐ ☐☐☐ ☐☐☐☐

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Chronic Condition Information

NOTE: This section is to be completed only if applying for a Clear Spring Health Chronic Special Needs Plan (CSNP). To be eligible for these plans, you must have one of these conditions: Diabetes, Chronic Heart Failure (CHF), or Cardiovascular Disorder (CVD). Please note: Once your enrollment is processed and completed we will contact you to obtain your treating physician's contact information to verify your qualifying condition. Please answer the questions below.

Have you ever been told by a doctor that you have diabetes? (sugar)	☐ Yes	☐ No
Have you ever been told by a doctor or clinic that you have Congestive Heart Failure? (such as fluid in the lungs or a weak heart)	☐ Yes	☐ No
Have you ever been told by a doctor or clinic that you have Cardiac Arrhythmias? (an irregular heart beat or that your heart flutters or races)	☐ Yes	☐ No
Have you ever been told by a doctor or clinic that you have Coronary Artery Disease? (blocked arteries, had stents or heart bypass surgery, or a heart attack)	☐ Yes	☐ No
Have you ever been told by a doctor or clinic that you have Peripheral Vascular Disease? (poor blood flow to the legs; pain, burning or achiness in your legs when you walk, but goes away when you sit down)	☐ Yes	☐ No
Have you ever been told by a doctor or clinic that you have Chronic Venous Thromboembolic Disorder? (blood clots or are you taking medication for blood clots)	☐ Yes	☐ No

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Answer These Important Questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Clear Spring Health? ☐ Yes ☐ No

Name of other coverage

Member # for this coverage	**Group # for this coverage**

Primary Care Physician (PCP) Selection - Optional

Please choose a Primary Care Physician (PCP), clinic or health center if enrolling in an HMO.

Name of PCP or facility

PCP ID # or Network # (If not available leave blank)

Address

City	**State**	**Zip Code**

Phone Number of PCP or facility

This section is intentionally left blank please go on to the next page.

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IMPORTANT: Read and Sign Below

I must keep Hospital (Part A) or Medical (Part B) to stay in Clear Spring Health.

By joining this Medicare Advantage Plan, I acknowledge that Clear Spring Health will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).

I understand that when my Clear Spring Health coverage begins, I must get all of my medical and prescription drug benefits from Clear Spring Health. Benefits and services provided by Clear Spring Health and contained in my Clear Spring Health "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Clear Spring Health will pay for benefits or services that are not covered.

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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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.

Signature	**Today's Date** (mm/dd/yyyy)

If you're the authorized representative, sign above and fill out these fields:

First Name	**Last Name**
Address	
Phone Number	**Relationship to Enrollee**

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

First Name	**Last Name**
Agency Name	
Agent/Broker NPN	**Referring Agent Number**

For Office Use Only

Date application received by Agent/Broker	**Proposed Effective Date** (mm/dd/yyyy)
☐ ICEP/IEP ☐ OEP ☐ AEP	**SEP** (type)

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SECTION 2: All Fields on This Page Are Optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

1. Are you 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.**

2. What's your race? (Select all that apply)

- ☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ White
- ☐ **I choose not to answer.**

3. What's your gender? (Select one)

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____
- ☐ **I choose not to answer.**

4. Which of the following best represents how you think of yourself? (Select one)

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ I don't know
- ☐ **I choose not to answer**

Select the box below if you would prefer us to send you information in a language other than English.

- ☐ Spanish

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Please contact Clear Spring Health at (877) 364-4566 if you need information in an accessible format or language other than what is listed above. Our office hours are October 1–March 31, 8:00 a.m.–8:00 p.m. seven days a week, and from April 1 - September 30, Monday through Friday, 8:00 a.m.–8:00 p.m. (you may leave a voicemail Saturday, Sunday and Federal Holidays). TTY users can call 711.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

Email Opt-In

☐ By providing my email address, I agree to receive the Evidence of Coverage, Summary of Benefits, the Annual Notice of Change as well as other communications through email. I can change this consent at any time by contacting member services. I will continue to receive important plan information by mail.

Text Opt-In

☐ I consent to receive important messages regarding my plan through text/SMS messages. Message and data rates may apply. You may text STOP to opt out, or HELP for more information.

PRIVACY 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 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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PAYING YOUR PLAN PREMIUM AND/ OR LATE ENROLLMENT PENALTY

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 having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay Clear Spring Health the Part D-IRMAA.

Note: If you are enrolling in a $0 premium plan, and you owe a late enrollment penalty or are assessed a Part D-IRMAA, that amount is considered your plan premium

Please select a premium payment option below (if you don't select a payment option, you will get a bill each month).

☐ **Get a Bill**

☐ **Electronic Funds Transfer (EFT) from your bank account each month.**
☐ Checking ☐ Savings

Account Holder's First Name

Account Holder's Last Name

Bank Routing Number

Bank Account Number

☐ **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.)