2025 MEDICARE ADVANTAGE INDIVIDUAL ENROLLMENT REQUEST FORM

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

Clear Spring Health
Enabling A Life Well Lived™

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 on the following page before completing.
Select the plan you want to join.

COLORADO

☐ **Clear Spring Health Essential (HMO)**
$0 per month (H6379-001)

☐ **Clear Spring Health Essential (PPO)**
$0 per month (H8014-001)

GEORGIA

☐ **Clear Spring Health Select Plus (HMO)**
$0 per month (H6672-005)

☐ **Clear Spring Health Choice Plus (PPO)**
$0 per month (H9589-003)

ILLINOIS

☐ **Clear Spring Health Essential (HMO)**
$0 per month (H5454-001)

☐ **Clear Spring Health Community Advantage (HMO)**
$0 per month (H3071-002)

☐ **Clear Spring Health Essential (HMO)**
$0 per month (H5454-002)

Plans and Monthly Premium Costs	Service Counties
COLORADO	
Clear Spring Health Essential (HMO) $0 premium per month (H6379-001)	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
Clear Spring Health Essential (PPO) $0 premium per month (H8014-001)	Adams, Arapahoe, Boulder, Denver, Douglas, Jefferson, Larimer, Weld
GEORGIA	
Clear Spring Health Select Plus (HMO) $0 premium per month (H6672-005)	Baker, Baldwin, Banks, Barrow, Bibb, Bleckley, Bryan, Butts, Candler, Chatham, Chattahoochee, Cherokee, Clarke, Clayton, Clinch, Cobb, Coweta, Crawford, Dawson, DeKalb, Dodge, Dooly, Douglas, Elbert, Emanuel, Evans, Fannin, Fayette, Forsyth, Franklin, Fulton, Gilmer, Glascock, Greene, Gwinnett, Habersham, Hall, Hancock, Haralson, Harris, Hart, Heard, Henry, Houston, Irwin, Jackson, Jasper, Jefferson, Jenkins, Johnson, Jones, Lamar, Lincoln, Long, Lumpkin, Macon, Madison, Marion, McIntosh, Meriwether, Monroe, Montgomery, Morgan, Newton, Oconee, Oglethorpe, Paulding, Peach, Pickens, Pike, Polk, Pulaski, Putnam, Rabun, Rockdale, Schley, Screven, Spalding, Stephens, Talbot, Taliaferro, Tattnall, Taylor, Telfair, Towns, Treutlen, Turner, Twiggs, Union, Upson, Walton, Warren, Washington, Webster, Wheeler, White, Wilcox, Wilkes, Wilkinson
Clear Spring Health Choice (PPO) $0 premium per month (H9589-003)	
ILLINOIS	
Clear Spring Health Essential (HMO) $0 per month (H5454-001)	Boone, Clinton, Macoupoin, Madison, Ogle, St Clair, Stephenson, Winnebago
Clear Spring Health Essential (HMO) $0 per month (H5454-002)	Cook, DuPage, Kane, Kankakee, LaSalle, McHenry, Will
Clear Spring Health Community Advantage (HMO) $0 per month (H3071-002)	Boone, Cook, DuPage, Kane, McHenry, Ogle, Will, Winnebago

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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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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.
If enrolling in a PPO plan, this section is **not** applicable.

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: This is a $0 premium plan, however, if 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.**
☐ Checkings ☐ 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.)