Pre-Enrollment Checklist

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 877-384-1241 (TTY:711)

Understanding the Benefits

☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit clearspringhealthcare.com or call 877-384-1241 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 medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

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, 2020.

☐ 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).
Clear Spring Health
Enrollment Form Instructions

**ILLINOIS**

**Clear Spring Health Essential (HMO)**
- **Illinois H5454-001 (Rockford, Downstate areas)**
  Boone, Clinton, Macoupin, Madison, Ogle, St. Clair, Stephenson and Winnebago Counties
- **H5454-002 (Chicago Area)**
  Cook, DuPage, Kane, Kankakee, LaSalle, McHenry, Will

**Clear Spring Health Essential Plus (HMO)**
- **Illinois H5454-003 (Rockford, Downstate areas)**
  Boone, Clinton, Macoupin, Madison, Ogle, St. Clair, Stephenson and Winnebago Counties
- **Illinois H5454-004 (Chicago Area)**
  Cook, DuPage, Kane, Kankakee, LaSalle, McHenry, Will

**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 (HMO)  Clear Spring Health Essential Plus (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.
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 (HMO) (Chicago) $0.00 per month
- Clear Spring Health Essential (HMO) (Rockford, Downstate) $0.00 per month
- Clear Spring Health Essential Plus (HMO) (Chicago) $47.00 per month
- Clear Spring Health Essential Plus (HMO) (Rockford, Downstate) $47.00 per month

<table>
<thead>
<tr>
<th>LAST name:</th>
<th>FIRST name:</th>
<th>MIDDLE Initial:</th>
<th>Mr.</th>
<th>Mrs.</th>
<th>Ms.</th>
</tr>
</thead>
</table>

**Birth Date:**

___-___-___ (M M - D D - Y Y Y Y)

<table>
<thead>
<tr>
<th>Sex:</th>
<th>Home Phone Number: (<em><strong>) <em><strong>-</strong></em>-</strong></em></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ M</td>
<td>☐ F</td>
</tr>
<tr>
<td></td>
<td>Mobile Phone Number: (<em><strong>) <em><strong>-</strong></em>-</strong></em></td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Name (as it appears on your Medicare card):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Number: __ ___ - ___ ___ - ___ ___</td>
</tr>
</tbody>
</table>

**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.
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.

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:

Please read and answer these important questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have End-Stage Renal Disease (ESRD)?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Name of other coverage:</th>
<th>ID # for this coverage:</th>
<th>Group # for this coverage:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Are you a resident in a long-term care facility, such as a nursing home?</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
</tbody>
</table>

If “yes,” please provide the following information:

Name of Institution: ________________________________
Address of Institution (number and street): ________________________________
Phone Number of Institution: ________________________________

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Are you enrolled in your State Medicaid program?</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
</tbody>
</table>

If yes, please provide your Medicaid number: ________________________________

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Do you or your spouse work?</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
</tbody>
</table>

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 8:00 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. TTY users should call 711.
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: ____________
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.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Date Inserted</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am new to Medicare.</td>
<td></td>
</tr>
<tr>
<td>I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).</td>
<td></td>
</tr>
<tr>
<td>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) __ __ - __ __ - __ __ __ __.</td>
<td></td>
</tr>
<tr>
<td>I recently was released from incarceration. I was released on (insert date) __ __ - __ __ - __ __ __ __.</td>
<td></td>
</tr>
<tr>
<td>I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) __ __ - __ __ - __ __ __ __.</td>
<td></td>
</tr>
<tr>
<td>I recently obtained lawful presence status in the United States. I got this status on (insert date) __ __ - __ __ - __ __ __ __.</td>
<td></td>
</tr>
<tr>
<td>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) __ __ - __ __ - __ __ __ __.</td>
<td></td>
</tr>
<tr>
<td>I am 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) __ __ - __ __ - __ __ __ __.</td>
<td></td>
</tr>
<tr>
<td>I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for Medicare prescription drug coverage, but I haven’t had a change.</td>
<td></td>
</tr>
<tr>
<td>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) __ __ - __ __ - __ __ __ __.</td>
<td></td>
</tr>
<tr>
<td>I recently left a PACE program on (insert date) __ __ - __ __ - __ __ __ __.</td>
<td></td>
</tr>
<tr>
<td>I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare’s). I lost my drug coverage on (insert date) __ __ - __ __ - __ __ __ __.</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>I am leaving employer or union coverage on (insert date) __ __ - __ __ - __ __ __ __.</td>
</tr>
<tr>
<td>☐</td>
<td>I belong to a pharmacy assistance program provided by my state.</td>
</tr>
<tr>
<td>☐</td>
<td>My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.</td>
</tr>
<tr>
<td>☐</td>
<td>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) __ __ - __ __ - __ __ __ __.</td>
</tr>
<tr>
<td>☐</td>
<td>I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.</td>
</tr>
</tbody>
</table>

If none of these statements applies to you or you’re not sure, please contact Clear Spring Health at 877-384-1241, (TTY: 711) to see if you are eligible to enroll.

We are open 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.