

**2024 PRESCRIPTION DRUG PLAN (PART D)
INDIVIDUAL ENROLLMENT FORM**

OMB No. 0938-1378 | Expires: 7/31/2024



Who can use this form?	What happens next?
<p>People with Medicare who want to join a Medicare Prescription Drug Plan.</p> <p>To join a plan, you must:</p> <ul style="list-style-type: none"> • Be a United States citizen or be lawfully present in the U.S. • Live in the plan’s service area <p>Important: To join a Medicare Prescription Drug Plan, you must also have either, or both:</p> <ul style="list-style-type: none"> • Medicare Part A (Hospital Insurance) • Medicare Part B (Medical Insurance) 	<p>Mail your completed and signed form to: Clear Spring Health PO Box 278470 Miramar, FL 33027</p> <p>Fax your completed and signed form to: 1-866-643-6159 Attn: Clear Spring Health Enrollment Dept.</p> <p>Enroll online at: www.clearspringhealthcare.com</p> <p>Once we process your request to join, we’ll contact you by mail.</p>
When do I use this form?	How do I get help with this form?
<p>You can join a plan:</p> <ul style="list-style-type: none"> • 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 <p>Visit Medicare.gov to learn more about when you can sign up for a plan.</p>	<p>Call Clear Spring Health at 1-877-317-6082. TTY users can call 711. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.</p> <p>En español: Llame a Clear Spring Health al 1-877-317-6082/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.</p>
What do I need to complete this form?	Individuals experiencing homelessness
<ul style="list-style-type: none"> • Your Medicare Number (the number on your red, white, and blue Medicare card) • Your permanent address and phone number <p>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.</p> <p>Reminders:</p> <ul style="list-style-type: none"> • 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. 	<p>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.</p> <p>According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.</p> <p>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.</p>

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SECTION 1: All fields on this page are required (unless marked optional)

To enroll in a Clear Spring Health plan, select the plan you want to join.

Clear Spring Health Value Rx	
<input type="checkbox"/> Clear Spring Health Value Rx Alabama, Tennessee (PBP 009)	\$23.70 per month
<input type="checkbox"/> Clear Spring Health Value Rx Alaska (PBP 029)	\$26.20 per month
<input type="checkbox"/> Clear Spring Health Value Rx Arizona (PBP 023)	\$26.70 per month
<input type="checkbox"/> Clear Spring Health Value Rx Arkansas (PBP 016)	\$14.50 per month
<input type="checkbox"/> Clear Spring Health Value Rx California (PBP 027)	\$22.70 per month
<input type="checkbox"/> Clear Spring Health Value Rx Colorado (PBP 062)	\$27.20 per month
<input type="checkbox"/> Clear Spring Health Value Rx Connecticut, Massachusetts, Rhode Island, Vermont (PBP 060)	\$24.80 per month
<input type="checkbox"/> Clear Spring Health Value Rx Delaware, District of Columbia, Maryland (PBP 002)	\$25.80 per month
<input type="checkbox"/> Clear Spring Health Value Rx Florida (PBP 008)	\$25.30 per month
<input type="checkbox"/> Clear Spring Health Value Rx Georgia (PBP 007)	\$23.80 per month
<input type="checkbox"/> Clear Spring Health Value Rx Hawaii (PBP 028)	\$21.50 per month
<input type="checkbox"/> Clear Spring Health Value Rx Idaho, Utah (PBP 026)	\$29.30 per month
<input type="checkbox"/> Clear Spring Health Value Rx Illinois (PBP 014)	\$16.80 per month
<input type="checkbox"/> Clear Spring Health Value Rx Indiana, Kentucky (PBP 012)	\$19.60 per month
<input type="checkbox"/> Clear Spring Health Value Rx Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming (PBP 022)	\$28.80 per month
<input type="checkbox"/> Clear Spring Health Value Rx Kansas (PBP 021)	\$23.30 per month
<input type="checkbox"/> Clear Spring Health Value Rx Louisiana (PBP 018)	\$26.00 per month
<input type="checkbox"/> Clear Spring Health Value Rx Maine, New Hampshire (PBP 059)	\$21.30 per month
<input type="checkbox"/> Clear Spring Health Value Rx Michigan (PBP 010)	\$18.70 per month
<input type="checkbox"/> Clear Spring Health Value Rx Mississippi (PBP 017)	\$21.60 per month
<input type="checkbox"/> Clear Spring Health Value Rx Missouri (PBP 015)	\$27.30 per month
<input type="checkbox"/> Clear Spring Health Value Rx Nevada (PBP 024)	\$20.80 per month
<input type="checkbox"/> Clear Spring Health Value Rx New Jersey (PBP 001)	\$24.30 per month
<input type="checkbox"/> Clear Spring Health Value Rx New Mexico (PBP 061)	\$23.80 per month
<input type="checkbox"/> Clear Spring Health Value Rx North Carolina (PBP 005)	\$29.00 per month
<input type="checkbox"/> Clear Spring Health Value Rx Ohio (PBP 011)	\$23.30 per month
<input type="checkbox"/> Clear Spring Health Value Rx Oklahoma (PBP 020)	\$21.70 per month
<input type="checkbox"/> Clear Spring Health Value Rx Oregon, Washington (PBP 025)	\$23.20 per month
<input type="checkbox"/> Clear Spring Health Value Rx Pennsylvania, West Virginia (PBP 003)	\$29.30 per month
<input type="checkbox"/> Clear Spring Health Value Rx South Carolina (PBP 006)	\$21.10 per month
<input type="checkbox"/> Clear Spring Health Value Rx Texas (PBP 019)	\$18.30 per month
<input type="checkbox"/> Clear Spring Health Value Rx Virginia (PBP 004)	\$23.60 per month
<input type="checkbox"/> Clear Spring Health Value Rx Wisconsin (PBP 013)	\$34.30 per month

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SECTION 1 (continued)

First Name			Last Name			Middle Initial (Optional)		
Birthdate (mm/dd/yyyy)				Sex		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
Primary Phone Number				Alternate Phone Number (Optional)				
Email Address (Optional)								
Permanent Residence Street Address (Don't enter a P.O. Box)								
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	

Your Medicare Information

Medicare Number

Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Clear Spring Health? YES
 If "yes", please list your other coverage and your identification (ID) number(s) for this coverage: NO

Name of other coverage	Member ID# for this coverage
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Group ID# for this coverage

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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 Prescription Drug 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 Part D plan at a time - and that enrollment in this plan will automatically end my enrollment in another Part D plan.

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 State law 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 by Medicare.

Signature

Today's Date (mm/dd/yyyy)

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

First Name

Last Name

Address

City

State

Zip Code

Phone Number

Relationship to Enrollee

For internal office use only

To be filled out by staff member/agent/broker (if assisted in enrollment):

First Name

Last Name

Agency Name

Agent/Broker NPN

Referring Agent Number

For Office Use Only

Date application received by Agent/Broker (mm/dd/yyyy)

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 Indian
- Black or African American
- Chinese
- Filipino
- Guamanian or Chamorro
- Japanese
- Korean
- Native Hawaiian
- Other Asian
- Other Pacific Islander
- Samoan
- Vietnamese
- White
- 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

Please contact Clear Spring Health at 1-877-317-6082 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

List your Primary Care Physician (PCP), clinic, or health center:

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.

PAYING YOUR PLAN PREMIUM AND/OR LATE ENROLLMENT PENALTY

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 having it automatically taken out of your Social Security or Railroad Retirement Board 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. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Clear Spring Health the Part D-IRMAA.

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. Account type:

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.)

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.