2026 MEDICARE ADVANTAGE INDIVIDUAL ENROLLMENT REQUEST FORM

OMB No. 0938-1378 | Expires: 12/31/2026

Clear Spring Health

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 3040
Spring Hill, FL 34611

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.

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SECTION 1: Select the plan you would like to join.

COLORADO

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

☐ **Clear Spring Health Balance+ Diabetes & Heart (HMO C-SNP) H6379-002**
$0 per month

GEORGIA

☐ **Clear Spring Health BrightPath Advantage (HMO) H6672-005**
$0 per month

☐ **Clear Spring Health BrightPath Advantage (PPO) H9589-003**
$0 per month

☐ **Clear Spring Health Balance+ Diabetes & Heart (HMO C-SNP) H6672-003**
$0 per month

ILLINOIS

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

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

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

☐ **Clear Spring Health Balance+ Diabetes & Heart (HMO C-SNP) H5454-005**
$0 per month

☐ **Clear Spring Health Balance+ Diabetes & Heart (HMO C-SNP) H5454-006**
$0 per month (H5454-006)

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SECTION 1 (continued)

First Name	**Last Name**	Optional: **Middle Initial**
Birthdate (mm/dd/yyyy)	**Sex** ☐ Male ☐ Female	
Primary Phone Number		

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**

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**

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 CoronaryArtery 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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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**

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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.

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

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

I want to get the following materials via email. Select one or more.

☐ Evidence of Coverage

☐ Summary of Benefits

☐ Annual Notice of Change

☐ Other Communications

I can change this consent at any time by contacting member services. I will continue to receive important plan information by mail.

E-mail address:

PRIVACY ACT 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.

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**

Relationship to Enrollee

Agency Name

Agent/Broker NPN | **Referring Agent Number**

Signature

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PAYING YOUR PLAN PREMIUM AND/ OR LATE ENROLLMENT PENALTY

If you owe a late enrollment penalty (or if you currently have a late enrollment penalty). 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.

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.)