

**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 already have Hospital (Part A) and recently signed up for Medical (Part B). I want to join a Medicare Advantage Plan.
- I'm new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started on (insert date) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- I'm in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan. My plan was taken over by the state on (insert date). \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- 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) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- I recently was released from incarceration. I was released on (insert date) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- I recently obtained lawful presence status in the United States. I got this status on (insert date) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- 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) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- 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) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- 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) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

continued on reverse side

- I recently left a PACE program on (insert date) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare’s). I lost my drug coverage on (insert date) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- I am leaving employer or union coverage on (insert date) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- I belong to a pharmacy assistance program provided by my state.
- I lost my coverage because Medicare ended its contract with my plan. I got a letter from Medicare saying I could join another plan on. I lost coverage on (insert date) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- 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) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- 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) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- 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 lingüística. Llame al 1-877-364-4566 (TTY: 711).

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

Beneficiary: First name: \_\_\_\_\_ Last name: \_\_\_\_\_

# Medicare Advantage Individual Enrollment Request Form

## 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)

## 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](https://www.Medicare.gov) to learn more about when you can sign up for a plan.

## 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.

## 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](https://www.clearspringhealthcare.com)

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

## 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 2 para asistencia en español y un representante estará disponible para asistirle.

## 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.

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.

### 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.**

**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**

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Clear Spring Health Essential Plan (HMO)</b><br>\$0 per month (H6379-001) | <input type="checkbox"/> <b>Clear Spring Health Essential Plan (PPO)</b><br>\$0 per month (H8014-001) |
|---|---|

**Georgia**

- |   |  |
|---|--|
| <input type="checkbox"/> <b>Clear Spring Health Select Plus Plan (HMO)</b><br>\$0 per month (H6672-005) | <input type="checkbox"/> <b>Clear Spring Health Choice Plus (PPO)</b><br>\$0 per month (H9589-003) |
|---|--|

**Illinois**

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Clear Spring Health Essential Plan (HMO)</b><br>\$0 per month (H5454-001)           | <input type="checkbox"/> <b>Clear Spring Health Essential Plan (HMO)</b><br>\$0 per month (H5454-002) |
| <input type="checkbox"/> <b>Clear Spring Health Community Advantage Plan (HMO)</b><br>\$0 per month (H3071-002) |   |

**South Carolina**

- |  |   |
|--|---|
| <input type="checkbox"/> <b>Clear Spring Health Select Plan (HMO)</b><br>\$0 per month (H9403-004) | <input type="checkbox"/> <b>Clear Spring Health Gold Plus Plan (PPO)</b><br>\$0 per month (H2334-005) |
|--|---|

**Virginia**

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Clear Spring Health Essential Plan (HMO)</b><br>\$0 per month (H8293-001) | <input type="checkbox"/> <b>Clear Spring Health Essential Plan (PPO)</b><br>\$0 per month (H8014-002) |
|---|---|

Plans and Monthly Premium Costs	Service Counties
<b>Colorado</b>	
Clear Spring Health Essential Plan (HMO) \$0 per month (H6379-001)	Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Gilpin, Jefferson, Larimer, Pueblo, Weld
Clear Spring Health Essential Plan (PPO) \$0 per month (H8014-001)	Adams, Arapahoe, Boulder, Denver, Douglas, Jefferson, Larimer, Weld
<b>Georgia</b>	
Clear Spring Health Select Plus Plan (HMO) \$0 premium per month (H6672-005)	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
Clear Spring Health Choice Plan (PPO) \$0 premium per month (H9589-003)	
<b>Illinois</b>	
Clear Spring Health Essential Plan (HMO) \$0 per month (H5454-001)	Boone, Clinton, Macoupin, Madison, Ogle, St Clair, Stephenson, Winnebago
Clear Spring Health Essential Plan (HMO) \$0 per month (H5454-002)	Cook, DuPage, Kane, Kankakee, LaSalle, McHenry, Will
Clear Spring Health Community Advantage Plan (HMO) \$0 per month (H3071-002)	Boone, Cook, DuPage, Kane, McHenry, Ogle, Will, Winnebago
<b>South Carolina</b>	
Clear Spring Health Select Plan (HMO) \$0 premium per month (H9403-004)	Beaufort, Chester, Colleton, Fairfield, Greenville, Hampton, Jasper, Lee, Saluda, Spartanburg, Union
Clear Spring Health Gold Plus Plan (PPO) \$0 premium per month (H2334-005)	
<b>Virginia</b>	
Clear Spring Health Essential Plan (HMO) \$0 per month (H8293-001)	Alleghany, Amelia, Appomattox, Augusta, Bath, Buena Vista City, Caroline, Charles City, Chesterfield, Clarke, Colonial Heights, Covington City, Craig, Cumberland, Danville City, Dinwiddie, Emporia, Essex, Franklin, Franklin City, Galax City, Giles, Gloucester, Goochland, Greene, Greenville, Halifax, Hanover, Harrisonburg City, Henrico, Highland, Hopewell City, Isle of Wight, King and Queen, King William, Lexington, Lunenburg, Madison, Mathews, Mecklenburg, Montgomery, Nelson, New Kent, Nottoway, Petersburg City, Pittsylvania, Poquoson City, Powhatan, Prince George, Pulaski, Radford City, Rappahannock, Richmond, Richmond City, Roanoke, Roanoke City, Rockbridge, Rockingham, Salem, Southampton, Staunton City, Surry, Sussex, Warren, Waynesboro City
Clear Spring Health Essential Plan (PPO) \$0 per month (H8014-002)	Chesterfield, Colonial Heights, Hanover, Henrico, Hopewell City, Petersburg City, Richmond City

**Section 1 (continued)**

First Name:  Last Name:  Middle Initial (optional):

Birth Date: (mm/dd/yyyy)  Sex:  Male  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:

**Emergency contact information below is optional**

Emergency Contact:

Emergency Contact Phone Number:  Relationship to You:

**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  No

If “yes”, please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:

Member ID # 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:

**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 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):



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.

- |   |   |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian                |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Other Asian                    |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Other Pacific Islander         |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Samoan                         |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Vietnamese                     |
| <input type="checkbox"/> Guamanian or Chamorro            | <input type="checkbox"/> White                          |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> <b>I choose not to answer.</b> |
| <input type="checkbox"/> Korean                           |   |

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 (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

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.

**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. 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.)