ConnectiCare

Enrollment Request Form 2017

Please contact ConnectiCare, Inc. if you need information in another language or format (Braille).

To Enroll in ConnectiCare, Inc., Please Provide the Following Information:

Please check only one box for the Plan you want to enroll in.

☐ **Passage Plan 1 (HMO)** $24 Monthly Premium	☐ **Passage Plan 1 (HMO) with Dental** $58 Monthly Premium
☐ **Choice Plan 1 (HMO)** $188 Monthly Premium ☐ **Choice Plan 2 (HMO)** $0 Monthly Premium	☐ **Choice Plan 1 (HMO) with Dental** $222 Monthly Premium ☐ **Choice Plan 2 (HMO) with Dental** $34 Monthly Premium
☐ **Flex Plan 1 (HMO-POS)** $239 Monthly Premium ☐ **Flex Plan 2 (HMO-POS)** $123 Monthly Premium ☐ **Flex Plan 3 (HMO-POS)** $49 Monthly Premium	☐ **Flex Plan 1 (HMO-POS) with Dental** $273 Monthly Premium ☐ **Flex Plan 2 (HMO-POS) with Dental** $157 Monthly Premium ☐ **Flex Plan 3 (HMO-POS) with Dental** $83 Monthly Premium

Last Name: First Name: MI: ☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date: _____ /_____ /_____ MM / DD / YYYY | Sex: ☐ M ☐ F | Home Phone Number: (__ __ __) __ __ __ - __ __ __ __ | Primary Language:

Permanent Residence Street Address (P.O. Box is not allowed):

City: State: ZIP Code:

Mailing Address (only if different from Permanent Residence Address)
Street Address:

City: State: ZIP Code:

Emergency Contact: **Phone Number:** (__ __ __) __ __ __ - __ __ __ __ **Relationship to you:**

E-mail Address:

Medicare Claim Number: __ __ __ - __ __-__ __ __ __ __

Please choose the name of a Primary Care Physician (PCP).

Name:_______________________________ PCP # ________________________ ☐ Current Patient

Race/Ethnicity (optional): ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other

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 White - ConnectiCare Copy; Yellow - Member Copy

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) online, by phone, 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 RRB. DO NOT pay ConnectiCare, Inc. the Part D-IRMAA. If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

☐ Get a bill

☐ Electronic funds transfer (EFT) from my bank account each month

☐ Automatic deduction from my monthly Social Security or Railroad Retirement Board (RRB) benefit check.

(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.)

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp. If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Please Read and Answer These Important Questions

1. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No
   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.

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.
   Will you have other Prescription Drug Coverage in addition to ConnectiCare, Inc.? ☐ Yes ☐ No
   If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:
   Name of other coverage: ____________ ID # for this coverage: ____________ Group # for this coverage: ____________

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If "yes", please provide the following information: Name of Institution: ____________
   Address & Phone Number of Institution (number and street): ____________

4. Are you enrolled in your state Medicaid program? ☐ Yes ☐ No
   If yes, please provide your Medicaid number: ____________

5. Do you or your spouse work? ☐ Yes ☐ No

Please contact ConnectiCare at 1-800-224-2273 if you need information in another format or language. Our office hours are seven days a week from 8 a.m. – 8 p.m. TTY users should call 1-800-842-9710.

Please Read This Important Information and Sign on Page 4

If you currently have health coverage from an employer or union, joining ConnectiCare, Inc. could affect your employer or union health benefits. You could lose your employer or union health coverage if you join ConnectiCare, Inc. 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.

By completing this enrollment application, I agree to the following:
ConnectiCare, Inc. is a Medicare Advantage plan and has a contract with the federal government. Enrollment in ConnectiCare depends on contract renewal. 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. If I am enrolling in the Choice 2 Plan, I understand that if I do not have Medicare Prescription Drug Coverage, or creditable Prescription Drug Coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare Prescription Drug Coverage 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.

ConnectiCare, Inc. serves a specific service area. If I move out of the area that ConnectiCare, Inc. 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 ConnectiCare, Inc., I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from ConnectiCare, Inc. when I get it to know which rules I must follow in order to receive 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 ConnectiCare, Inc. coverage begins, I must get all of my health care from ConnectiCare, Inc., except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by ConnectiCare, Inc. and other services contained in my ConnectiCare, Inc. Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR CONNECTICARE, INC. 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 ConnectiCare, Inc., he/she may be paid based on my enrollment in ConnectiCare, Inc.

Release of Information: By joining this Medicare health plan, I acknowledge that ConnectiCare, Inc. will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that ConnectiCare, Inc. 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.

Please Complete This Section to Help Determine Which Election Period You Qualify For

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 boxes to all of the statements that apply 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 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 ___ /___ /_____.
- ☐ I recently was released from incarceration. I was released on ___ /___ /_____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ___ /___ /_____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on ___ /___ /_____.
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare Prescription Drug Coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on ___ /___ /_____.
- ☐ I am moving into, live in, or recently moved out of a Long Term Care Facility (for example, a nursing home). I moved/will move into/out of the facility on ___ /___ /_____.
- ☐ I recently left a PACE program on ___ /___ /_____.
- ☐ I recently involuntarily lost my creditable Prescription Drug Coverage (coverage as good as Medicare's). I lost my drug coverage on ___ /___ /_____.
- ☐ I am leaving employer or union coverage on ___ /___ /_____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ 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 ___ /___ /_____.

If none of these statements applies to you or you're not sure, please contact ConnectiCare, Inc. at 1-800-224-2273 (TTY users should call 1-800-842-9710) to see if you are eligible to enroll. We are open seven days a week from 8 a.m. – 8 p.m.

Please Sign Below

Your Signature:

Proposed Effective Date:	**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:** ☐ Power of Attorney ☐ Guardian ☐ Conservator ☐ None

For Company Use Only

Staff Member/Agent/Broker Signature: ______________________ Date Accepted: ___________

Agent/Broker ID: ____________________________ **SOA:** ☐ Yes ☐ No, Seminar ☐ No, Mail

Source Code: ☐ TM ☐ SEM ☐ SELF GEN

Election Period: ICEP/IEP: _______________ AEP: _______________ SEP Type: __________

Not Eligible: _______________

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