Clear Spring Health

OMB No. 0938-1378
Expires: 7/31/2023

Medicare Prescription Drug Plan Individual Enrollment Request Form

Who can use this form?

People with Medicare who want to join a Medicare Prescription Drug 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 Prescription Drug Plan, you must also have either, or 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 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 if you don't complete them.

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 278470
Miramar, FL 33027

Or

Fax your completed and signed form to:
1-866-643-6159
Attn: Clear Spring Health Enrollment Dept.

Or

Enroll online at:
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 1-877-317-6082. TTY users should 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 1-877-317-6082/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.

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 goernment.

Clear Spring Health

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Section 1 — All fields on this page are required (unless marked optional)

To enroll in a Clear Spring Health plan, check which one you want to enroll in.

Clear Spring Health Value Rx

- ☐ Clear Spring Health Value Rx Alabama, Tennessee (PBP 009) ..... $28.20 per month
- ☐ Clear Spring Health Value Rx Alaska (PBP 029) ..... $34.90 per month
- ☐ Clear Spring Health Value Rx Arizona (PBP 023) ..... $33.20 per month
- ☐ Clear Spring Health Value Rx Arkansas (PBP 016) ..... $25.20 per month
- ☐ Clear Spring Health Value Rx California (PBP 027) ..... $29.20 per month
- ☐ Clear Spring Health Value Rx District of Columbia, Delaware, Maryland (PBP 002) ..... $29.40 per month
- ☐ Clear Spring Health Value Rx Florida (PBP 008) ..... $29.40 per month
- ☐ Clear Spring Health Value Rx Georgia (PBP 007) ..... $26.50 per month
- ☐ Clear Spring Health Value Rx Hawaii (PBP 028) ..... $29.40 per month
- ☐ Clear Spring Health Value Rx Idaho, Utah (PBP 026) ..... $34.60 per month
- ☐ Clear Spring Health Value Rx Illinois (PBP 014) ..... $26.50 per month
- ☐ Clear Spring Health Value Rx Indiana, Kentucky (PBP 012) ..... $27.60 per month
- ☐ Clear Spring Health Value Rx Iowa, Minnesota, Montana, North Dakota, Nebraska, South Dakota,Wyoming (PBP 022) ..... $29.30 per month
- ☐ Clear Spring Health Value Rx Kansas (PBP 021) ..... $27.30 per month
- ☐ Clear Spring Health Value Rx Louisiana (PBP 018) ..... $31.90 per month
- ☐ Clear Spring Health Value Rx Michigan (PBP 010) ..... $28.40 per month
- ☐ Clear Spring Health Value Rx Mississippi (PBP 017) ..... $26.80 per month
- ☐ Clear Spring Health Value Rx Missouri (PBP 015) ..... $28.70 per month
- ☐ Clear Spring Health Value Rx Nevada (PBP 024) ..... $26.50 per month
- ☐ Clear Spring Health Value Rx New Jersey (PBP 001) ..... $34.20 per month
- ☐ Clear Spring Health Value Rx North Carolina (PBP 005) ..... $28.20 per month
- ☐ Clear Spring Health Value Rx Ohio (PBP 011) ..... $40.90 per month
- ☐ Clear Spring Health Value Rx Oklahoma (PBP 020) ..... $27.20 per month
- ☐ Clear Spring Health Value Rx Oregon,Washington (PBP 025) ..... $33.50 per month
- ☐ Clear Spring Health Value Rx Pennsylvania,West Virginia (PBP 003) ..... $32.80 per month
- ☐ Clear Spring Health Value Rx South Carolina (PBP 006) ..... $27.20 per month
- ☐ Clear Spring Health Value Rx Texas (PBP 019) ..... $38.10 per month
- ☐ Clear Spring Health Value Rx Virginia (PBP 004) ..... $28.90 per month
- ☐ Clear Spring Health Value Rx Wisconsin (PBP 013) ..... $35.30 per month

Section 1 continued

Clear Spring Health Premier Rx

- ☐ Clear Spring Health Premier Rx Alabama, Tennessee (PBP 038) ..... $16.30 per month
- ☐ Clear Spring Health Premier Rx Alaska (PBP 058) ..... $15.50 per month
- ☐ Clear Spring Health Premier Rx Arizona (PBP 052) ..... $29.10 per month
- ☐ Clear Spring Health Premier Rx Arkansas (PBP 045) ..... $16.80 per month
- ☐ Clear Spring Health Premier Rx California (PBP 056) ..... $16.00 per month
- ☐ Clear Spring Health Premier Rx District of Columbia, Delaware, Maryland (PBP 031) ..... $17.20 per month
- ☐ Clear Spring Health Premier Rx Florida (PBP 037) ..... $19.70 per month
- ☐ Clear Spring Health Premier Rx Georgia (PBP 036) ..... $18.20 per month
- ☐ Clear Spring Health Premier Rx Hawaii (PBP 057) ..... $16.70 per month
- ☐ Clear Spring Health Premier Rx Idaho, Utah (PBP 055) ..... $16.10 per month
- ☐ Clear Spring Health Premier Rx Illinois (PBP 043) ..... $17.70 per month
- ☐ Clear Spring Health Premier Rx Indian, Kentucky (PBP 041) ..... $22.20 per month
- ☐ Clear Spring Health Premier Rx Iowa, Minnesota, Montana, North Dakota, Nebraska, South Dakota,Wyoming (PBP 051) ..... $16.60 per month
- ☐ Clear Spring Health Premier Rx Kansas (PBP 050) ..... $16.70 per month
- ☐ Clear Spring Health Premier Rx Louisiana (PBP 047) ..... $16.20 per month
- ☐ Clear Spring Health Premier Rx Michigan (PBP 039) ..... $17.00 per month
- ☐ Clear Spring Health Premier Rx Mississippi (PBP 046) ..... $18.50 per month
- ☐ Clear Spring Health Premier Rx Missouri (PBP 044) ..... $40.20 per month
- ☐ Clear Spring Health Premier Rx Nevada (PBP 053) ..... $16.00 per month
- ☐ Clear Spring Health Premier Rx New Jersey (PBP 030) ..... $18.70 per month
- ☐ Clear Spring Health Premier Rx North Carolina (PBP 034) ..... $18.10 per month
- ☐ Clear Spring Health Premier Rx Ohio (PBP 040) ..... $17.00 per month
- ☐ Clear Spring Health Premier Rx Oklahoma (PBP 049) ..... $16.40 per month
- ☐ Clear Spring Health Premier Rx Oregon,Washington (PBP 054) ..... $16.20 per month
- ☐ Clear Spring Health Premier Rx Pennsylvania, West Virginia (PBP 032) ..... $18.20 per month
- ☐ Clear Spring Health Premier Rx South Carolina (PBP 035) ..... $16.50 per month
- ☐ Clear Spring Health Premier Rx Texas (PBP 048) ..... $17.70 per month
- ☐ Clear Spring Health Premier Rx Virginia (PBP 033) ..... $23.20 per month
- ☐ Clear Spring Health Premier Rx Wisconsin (PBP 042) ..... $16.70 per month

Clear Spring Health

Medicare Prescription Drug Plan Individual Enrollment Request Form

Section 1 continued. To enroll, please provide the following information:

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 (do not enter a P.O. Box):

City: State: ZIP Code:

Mailing Address (only if different from your Permanent Address):

City: State: ZIP Code:

Emergency contact information below is optional

Emergency Contact:

Emergency Contact Phone Number: Relationship to You:

Your Medicare information:

Medicare Number: ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Please read and 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:

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

Please select the box below if you would prefer us to send you information in a language other than English.
☐ Spanish

Please select a box below if you want us to send you information in an accessible format.
☐ Braille ☐ Large print ☐ Audio CD

Please contact Clear Spring Health at (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 should call: 711.

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Medicare Prescription Drug Plan Individual Enrollment Request Form

Paying your plan premium and/or late enrollment penalty:

You can pay your monthly plan premium (including any late enrollment penalty you 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 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:

☐ Receive a bill

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

Account type: ☐ Checking ☐ Savings

Account holder's name:

First name: _____ 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/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please read and sign below

- I must keep my Medicare Part A or Part B coverage.
- By joining this Medicare Prescription Drug Plan, I acknowledge that Clear Spring Health will release my information to Medicare, who may use it to track beneficiary enrollment, for payment and other purposes applicable to Federal statutes that authorize the collection of this information (see Privacy Act Statement on the following page).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- 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):** _____

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AUTHORIZED REPRESENTATIVE: If you are the authorized representative, you must sign above and provide the following information:

First name:

Last name:

Address:

City:

State:

Zip:

Phone Number:

Relationship to Enrollee:

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 and 1860D-1 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 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 Writing Number:

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):

☐ **Not eligible**

Clear Spring Health

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Prescription Drug 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 Prescription Drug 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'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 had Medicare prior to now, but I'm now turning 65.
- ☐ 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). ____ / ____ / ____
- ☐ I recently left a PACE program on (insert date). ____ / ____ / ____

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Clear Spring Health

Attestation of Eligibility for an Enrollment Period

- ☐ 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 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.

If none of these statements applies to you or you're not sure, please contact Clear Spring Health at 1-877-317-6082 (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 linguistica. Llame al 1-877-317-6082 (TTY: 711).

Beneficiary: First name: _____ Last name: _____

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