Please contact CareSource if you need information in another language or format (Braille).

| **To Enroll in CareSource Dual Advantage™ (HMO SNP), Please Provide the Following Information:** | | | |
|---|---|---|---|
| LAST name: FIRST name: Middle Initial: | | | ☐Mr. ☐Mrs. ☐Ms. |
| Birth Date: (_ _ /_ _ /_ _ _ _) (MM/DD/YYYY) | Sex: ☐M ☐F | Home Phone Number: ( ) - | Alternate Phone Number: ( ) - |
| Permanent Residence Street Address (P.O. Box is not allowed) | | | |
| City: | County: | State: | ZIP Code: |
| Mailing Address (only if different from your Permanent Residence Address): Street Address: _____ City: _____ State: _____ ZIP Code:_____ | | | |
| E-mail Address: | | | |

| **Please Provide Your Medicare Insurance Information** | |
|---|---|
| Please take out your red, white and blue Medicare card to complete this section.<br>• Fill out this information as it appears on your Medicare card.<br>**-OR-**<br>• Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. | Name (as it appears on your Medicare card): _____<br>Medicare Number: _____<br>Is Entitled To: Effective Date:<br>HOSPITAL (Part A) _____<br>MEDICAL (Part B) _____<br>You must have Medicare Part A and Part B to join a Medicare Advantage plan. |

# Paying Your Plan Premium

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.

If you don't select a payment option, you will get a bill each month.

**Please select a premium payment option:**

- ☐ Get a bill
- ☐ 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, well send you a paper bill for your monthly premiums.)

**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 CareSource Dual Advantage? ☐ 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 (number and street) and Phone Number of Institution: _____

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

6. Are you a Qualified Medicare Beneficiary, Qualified Medicare Beneficiary+ or Full-Benefit Dual Eligible? (i.e. have you received a letter from Ohio Medicaid advising you that you have QMB, QMB+, or FBDE status?) ☐ Yes ☐ No

**6. Please choose the name of a Primary Care Physician (PCP), clinic, or health center:**

**Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:**

☐ Spanish ☐ Large Print

Please contact CareSource at 1-833-230-2020 if you need information in accessible format or language other than what is listed above. Our office hours are 8 a.m. to 8 p.m. Monday through Friday, and from October 1 through March 31 we are open the same hours 7 days a week. TTY users should call 711.

## Please Read and Sign Below

**By completing this enrollment application, I agree to the following:**

CareSource is a Medicare Advantage plan and has a contract with the Federal government. 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. 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: Oct. 15–Dec. 7 of every year), or under certain special circumstances.

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

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

| **Signature:** | **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:** _____

**Office Use Only:**

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP:_____ AEP:_____ SEP (type):_____ Not Eligible: _____

Agent/Broker Writing # or National Producer #: _____

Agent Receipt Date: _____