CareSource
Health Care with Heart

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

To Enroll in CareSource Advantage® (HMO) / CareSource Advantage Plus™ (HMO) / CareSource Advantage Zero Premium™ (HMO), Please Provide the Following Information:

Please check which plan you want to enroll in:

☐ CareSource Advantage Zero Premium $0 per month

☐ CareSource Advantage $32.10 per month

☐ CareSource Advantage Plus $56.60 per month

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 Medicare card to complete this section

· Please fill in these blanks so they match your red, white and blue Medicare card

"**OR**"

· Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board

You must have Medicare Part A and Part B to join a Medicare Advantage plan

SAMPLE ONLY

Name: _____

Medicare Claim Number: Sex: _____

_ _ _-_ _ -_ _ _ _ ___

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Paying Your Plan Premium

With the Zero Premium Plan – 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 prefer to pay it. You can pay by mail, electronic check, credit card, debit card, or by phone each month or quarterly. 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 the RRB. DO NOT pay CareSource the Part-D IRMAA.

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe, by mail, electronic check, credit card, debit card, or by phone 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 or quarterly.

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe, by mail, electronic check, credit card, debit card, or by phone 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 form your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay CareSource the Part D-IRMAA.

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. (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 anymore, **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? ☐ 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 and 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

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 another format: ☐ Large Print

Please contact CareSource at 1-888-222-9924 if you need information in another format or language than what is listed above. Our office hours are open 8 a.m. - 8 p.m. Monday through Friday, and from Oct. 1 - Feb. 14 we are open the same hours 7 days a week. TTY users should call 1-800-648-6056 or 711.

Please Read this Important Information

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

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: _____

For 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: _____

CareSource – H1493

2017 Medicare Star Ratings*

The Medicare Program rates all health and prescription drug plans each year, based on a plan's quality and performance. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.
2. Summary Star Rating that focuses on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

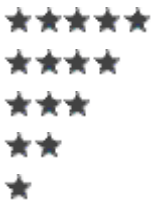
For 2017, CareSource received the following Overall Star Rating from Medicare.

Plan too new to be measured

We received the following Summary Star Rating for CareSource's health/drug plan services:

Health Plan Services:	Plan too new to be measured
Drug Plan Services:	Plan too new to be measured

The number of stars shows how well our plan performs.



5 stars - excellent
4 stars - above average
3 stars - average
2 stars - below average
1 star - poor

Learn more about our plan and how we are different from other plans at www.medicare.gov.

You may also contact us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time at 1-888-222-9924 (toll-free) or 1-800-648-6056 (TTY), from October 1 to February 14. Our hours of operation from February 15 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

Current members please call 1-800-833-3239 (toll-free) or 1-800-648-6056 (TTY).

*Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.

CareSource is a managed care organization with a Medicare contract. Enrollment in CareSource Advantage Zero Premium™ (HMO), CareSource Advantage® (HMO) and CareSource Advantage Plus™ (HMO) depends on contract renewal.

CareSource complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

Si usted o alguien a quien ayuda tienen preguntas sobre CareSource, tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, Por favor, llame al número de Servicios para Afiliados que figura en su tarjeta de identificación.

如果您或者您在帮助的人对 CareSource 存有疑问，您有权 免费获得以您的语言提供的帮助和信息。 如果您需要与一 位翻译交谈，请拨打您的会员 ID 卡上的会员服务电话号码。

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SPANISH

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-833-3239 TTY:711.

ENGLISH

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-833-3239 TTY:711.

CHINESE

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-833-3239 TTY:711。

GERMAN

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-833-3239 TTY:711.

ARABIC

ملحوظة: إذا كنت تتحدث اذكر اللغة, فإن خدمات المساعدة اللغوية تتوافر للك بالمجان. اتصل برقم 1-800-833-3239, رقم هاتف الصم والبكم: 711.

PENNSYLVANIA DUTCH

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-833-3239 TTY:711.

RUSSIAN

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-833-3239 телетайп: 771.

FRENCH

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-833-3239 TTY:711.

VIETNAMESE

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-833-3239 TTY:711.

CUSHITE/OROMO

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-833-3239 TTY:711.

KOREAN

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-833-3239 TTY:711 번으로 전화해 주십시오.

ITALIAN

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-833-3239 TTY:711.

JAPANESE

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-833-3239 TTY:711まで、お電話にてご連絡ください。

DUTCH

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-833-3239 TTY:711.

UKRAINIAN

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-833-3239 телетайп:711.

ROMANIAN

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-833-3239 TTY:711.

NEPALI

ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नमि्तभिाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् 1-800-833-3239 टटिेवाइ: 711।

SOMALI

DIGTOONI: Haddii aad ku hadasho Af Soomaali, adeegyada caawimada luqada, oo lacag la'aan ah, ayaa laguu heli karaa adiga. Wac 1-800-833-3239 TTY: 711.

CareSource®