

2010 MEDICARE ADVANTAGE INDIVIDUAL ENROLLMENT REQUEST FORM

TO ENROLL IN CLEAR ONE HEALTH PLANS, PLEASE PROVIDE THE FOLLOWING INFORMATION

Please check which plan you want to enroll in:

- | | | |
|--|--|---|
| <input type="checkbox"/> VALUE PLAN (HMO) \$124 | <input type="checkbox"/> TRADITIONAL PLAN (HMO-POS) \$140 | <input type="checkbox"/> EXPLORER + RX PLAN (PPO) \$147 |
| <input type="checkbox"/> VALUE + RX PLAN (HMO) \$153 | <input type="checkbox"/> TRADITIONAL + RX PLAN (HMO-POS) \$186 | |

| | | | | | | |
|--|--|--------------------------|--|------|---|----------|
| LAST NAME | | FIRST NAME | | MI | <input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MS. | |
| BIRTH DATE ____/____/____ MM / DD / YYYY | SEX <input type="checkbox"/> M <input type="checkbox"/> F | EMAIL ADDRESS (optional) | | | HOME PHONE NUMBER () | |
| PERMANENT RESIDENCE STREET ADDRESS (PO Box is not allowed) | | | | CITY | STATE | ZIP Code |
| MAILING ADDRESS (if different from above) | | | | CITY | STATE | ZIP Code |

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION


Please take out your Medicare card to complete this section.

- Please fill in the blanks so they match your red, white and blue Medicare Card

- OR -

- Attach a copy of your Medicare Card or your letter from the Social Security Administration or the Railroad Retirement Board

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

| | |
|--|----------------------|
|  | SAMPLE |
| Name _____ | |
| Medicare Claim Number _____ | Sex: _____ |
| Is Entitled To: _____ | Effective Date _____ |
| HOSPITAL (PART A) _____ | |
| MEDICAL (PART B) _____ | |

PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

- Do you have End Stage Renal Disease (ESRD)? YES NO
If you answered "yes" to this question and you don't need regular dialysis any more, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant.
- 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 Clear One Health Plans? 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: _____
- 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): _____
- Are you enrolled in your State Medicaid program? YES NO
If yes, please provide your Medicaid number: _____

PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS - continued

5. Do you or your spouse work? YES NO

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

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

- Other languages (please call for available languages)
- Electronic formats
- Large Print

Please contact Clear One Health Plans at (888) 863-3637 or (541) 385-5315 if you need information in another format or language than what is listed above. Our office hours are 7AM - 8PM, 7 days a week. (TTY users should call (800) 735-2900)

PLEASE READ THIS IMPORTANT INFORMATION

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

PAYING YOUR PLAN PREMIUM

You can pay your monthly plan premium by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

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

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

Please enclose a VOIDED check or provide the following:

1. Account Holder Name 2. Account Type 3. Bank Routing Number 4. Bank Account Number

Automatic Deduction from your monthly Social Security benefit check.

(The Social Security deductions may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you don't add or drop your prescription drug coverage (i.e. if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage you can only change to another plan without Medicare prescription drug coverage). Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

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 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 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 (insert date)_____.
- 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)_____.
- 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 recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- None of these statements applies to me.*

* Please contact Clear One Health Plans at 1-888-863-3637 (TTY users should call 1-800-735-2900) to see if you are eligible to enroll. We are open 7AM-8PM, 7 days a week.

PLEASE READ AND SIGN BELOW

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

Clear One Health Plans 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. I understand that if I don't 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: November 15 – December 31 of every year), or under certain special circumstances.

Continued on next page →

PLEASE READ AND SIGN BELOW - continued

Clear One Health Plans serves a specific service area. If I move out of the area that Clear One Health Plans 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 Clear One Health Plans, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Clear One Health Plans when I get it to know which rules I must follow in order 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 **Value Plan (HMO)** or **Value + RX Plan (HMO)** coverage begins, I must get all of my health care from Clear One Health Plans, except for emergency or urgently needed services or out-of-area dialysis services.

Traditional Plan (HMO-POS) and Traditional + RX Plan (HMO-POS) members have the option to receive some services from either in-network or out-of-network providers for doctor office visits. Please see the Evidence of Coverage document for additional information.

Explorer + RX (PPO) members have the option to receive all covered services from either in-network or out-of-network providers. I understand that beginning on the date Clear One Health Plans coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-network dialysis services. If medically necessary, Clear One Health Plans provides refunds for all covered benefits, even if I get services out-of-network.

Services authorized by Clear One Health Plans and other services contained in my Clear One Health Plans' Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR CLEAR ONE HEALTH PLANS 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 Clear One Health Plans, he/she may be paid based on my enrollment in Clear One Health Plans.

Release of Information: By joining this Medicare health plan, I acknowledge that Clear One Health Plans will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Clear One Health Plans will release my information including my prescription drug event data for the Traditional + RX Plan (HMO-POS), Explorer + RX Plan (PPO), and Value + RX Plan (HMO) 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 by Clear One Health Plans or by Medicare.

SIGNATURE: _____ **TODAY'S DATE:** _____

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

Name: _____

Address: _____

Phone Number: _____ Relationship to Enrollee: _____

Office Use Only: Plan ID# _____

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

Effective Date of Coverage: _____ ICEP/IEP OEP AEP SEP(type) Not Eligible

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Toll Free 888.863.3637 Web www.clearonehp.com

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