



2010 MEDICARE ADVANTAGE
SHORT ENROLLMENT REQUEST FORM
OREGON

Name of Plan You are Enrolling In:

- | | | |
|--|--|---|
| <input type="checkbox"/> Value Plan (HMO) | <input type="checkbox"/> Traditional Plan (HMO - POS) | <input type="checkbox"/> Explorer + Rx Plan (PPO) |
| <input type="checkbox"/> Value + Rx Plan (HMO) | <input type="checkbox"/> Traditional + Rx Plan (HMO - POS) | |

NAME:

MEDICARE NUMBER:

Home Phone Number:

Email Address (Optional):

Permanent Street Address:

City:

State:

Zip Code:

MAILING ADDRESS (only if different from your Permanent Street Address):

City:

State:

Zip Code:

PLEASE FILL OUT THE FOLLOWING:

I am currently a member of the:

- | | | |
|--|--|--|
| <input type="checkbox"/> Value Plan (HMO) | <input type="checkbox"/> Traditional Plan (HMO - POS) | <input type="checkbox"/> Explorer + Rx Plan (PPO) |
| <input type="checkbox"/> Value + Rx Plan (HMO) | <input type="checkbox"/> Traditional + Rx Plan (HMO - POS) | <input type="checkbox"/> PERS Traditional Plan (HMO) |

With a monthly premium of \$_____.

I would like to change to the:

- | | | |
|--|--|---|
| <input type="checkbox"/> Value Plan (HMO) | <input type="checkbox"/> Traditional Plan (HMO - POS) | <input type="checkbox"/> Explorer + Rx Plan (PPO) |
| <input type="checkbox"/> Value + Rx Plan (HMO) | <input type="checkbox"/> Traditional + Rx Plan (HMO - POS) | |

I understand that this plan has different health benefits and a monthly premium of \$_____.

Name of chosen Primary Care Physician (PCP):

Please check one of the boxes below if you would prefer us to send you information in a language other than English or 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 other than what is listed. Our office hours are 7AM – 8PM, 7 days a week. (TTY users should call (800) 735-2900)

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 Check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, 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 won't have a coverage gap or late enrollment penalty. Many people qualify 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 for this benefit. 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
- Monthly Electronic Funds Transfer (EFT)
- Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction 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.)

PLEASE READ AND SIGN BELOW:

Clear One Health Plans is a plan that has a contract with the Federal Government.

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 the Medicare health plan 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 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 people with Medicare aren't 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 for additional information.

Explorer + RX Plan (PPO) members have the option to receive all covered services from either in-network or out-of-network providers. I understand the 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 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 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: _____ OEP: _____ AEP: _____ SEP(type): _____ Not Eligible: _____