PRE-ENROLLMENT CHECKLIST

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Medicare Specialist at 1-877-665-2622

Understanding the Benefits

☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit https://www.cnchealthplan.com or call 1-877-665-2622 to view a copy of the EOC.

☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2020.

☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

Y0107_H2171_19_178_C

care n care
Insurance Company, Inc.

2019

ENROLLMENT FORM INSTUCTIONS

Care N' Care is a Medicare Advantage organization offering both HMO and PPO plans. You must reside in one of these counties to qualify: **Collin, Dallas, Denton, Hood, Johnson, Parker, Rockwall, Tarrant, and Wise.**

Please complete the Enrollment Request Form on the next page using the instructions below. You can also enroll with Care N' Care over the phone by calling us at the number listed below or by going online at cnchealthplan.com/enroll.

Plan Information

- Choose the plan that best fits your needs.
- Write in the name of the Primary Care Physician (PCP) you have selected. Need a PCP? Locate one near you by searching our online directory at www.cnchealthplan.com/search.
- You must select and list an in-network Primary Care Physician (PCP), if you choose the HMO plan.
- You understand that the plan you have chosen is NOT a Medicare supplement (Medigap plan).

Applicant Information

- You must complete a separate form for each person enrolling in our plan.
- Please write your name exactly as it appears on your red, white, and blue Medicare card. This is how it will appear on your member ID card.
- Incomplete information may delay your enrollment.
- You understand that you must continue to pay my Medicare Part B Premium.

Sign and Date Enrollment Request Form

- Complete all sections of the enrollment request form in full, including the plan you want to enroll in and your premium payment option. Missing or incomplete information may cause a delay in the effective date of your coverage.
- Your enrollment request form must be signed, dated, and received by Care N' Care by the last calendar day of the month in order for your coverage to be effective the first day of the following month.
- If your authorized representative helped you complete this form, he/she must sign the form and submit a copy of the court order or Durable Power of Attorney that allows them to act on your behalf, if requested by the plan.
- Care N' Care determines when your enrollment request form is considered to be complete based on Medicare enrollment guidelines.
- Your enrollment with Care N' Care is subject to approval by the Centers for Medicare & Medicaid Services (CMS). If your enrollment is not accepted by CMS, we will notify you immediately.

Return the Enrollment Request Form

- Mail the completed enrollment form to:

  Care N' Care Insurance Co., Inc.
  1701 River Run, Suite 402
  Fort Worth, TX 76107

Questions? Call Care N' Care!
Toll-Free at 1-877-665-2622 (TTY users should call 711) 8AM - 8PM (CST) seven days a week.

Care N' Care Insurance is an HMO and PPO plan with a Medicare contract.
Enrollment in Care N' Care depends on contract renewal.

Individual Enrollment Request Form - 2019

care n care
Insurance Company, Inc.

Please contact Care N' Care if you need information in another language or format (Braille).

To Enroll in Care N' Care Health Plans, Please Provide the Following Information:

Please check which plan you want to enroll in:

☐ Care N' Care Classic HMO $0 per month

Optional Supplemental Benefits Rider:
☐ Care N' Care Dental Rider $18 per month

LAST Name:	FIRST Name:	Middle Initial:	☐ Mr. ☐ Ms. ☐ Mrs.
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:	County:	State:	ZIP Code:

Emergency Contact:	Phone Number:	Relationship to You:

E-mail Address:

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

-OR-

- 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): ______________________

Medicare Number: ______________________

Is Entitled To: Effective Date:

HOSPITAL (Part A) ____________

MEDICAL (Part B) ____________

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

Y0107_H2171_19_151_M

Individual Enrollment Request Form - 2019

care n care
Insurance Company, Inc.

Paying Your Plan Premium

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 would prefer to pay it. You can pay 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 (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 Care N' Care 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 Monthly

☐ Electronic funds transfer (EFT) from your bank account each month.
Please enclose a VOIDED check or provide the following:

Account Holder Name: ______________________________

Bank Routing Number: ______________________________

Bank Account Number: ______________________________

Account type: ☐ Checking ☐ Savings

☐ 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, we will send you a paper bill for your monthly premiums.)

Y0107_H2171_19_151_M

Individual Enrollment Request Form - 2019

care n care
Insurance Company, Inc.

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. ☐ Yes ☐ No
Will you have other prescription drug coverage in addition to Care N' Care Health Plan?
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 & 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

Please choose the name of a 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 in an accessible format: ☐ Spanish ☐ Large Print

Please contact Care N' Care at 1-877-374-7993, if you need information in an accessible format or a language other than what is listed above. Our office hours are 8 AM to 8 PM, seven days a week (CST) from October 1st to March 31, and 8 AM to 8 PM Monday through Friday, from April 1 to September 30th. TTY users should call 711.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Care N' Care Health Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Care N' Care Health Plan. 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:
Care N' Care 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.

Y0107_H2171_19_151_M

Individual Enrollment Request Form - 2019

care n care
Insurance Company, Inc.

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: October 15 – December 7 of every year), or under certain special circumstances.

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

Release of Information: By joining this Medicare health plan, I acknowledge that Care N' Care will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Care N' Care 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: ____________________ Relationship to Enrollee: ____________

Address: ____________________ Phone Number: ____________

Office Use Only:

Name of agent/broker (if assisted in enrollment): ____________ NPN Number: ________

Plan ID#: ________ Effective Date of Coverage: ____________

Date Application Received by Agent: ____________

ICEP/IEP: ______ AEP: ______ SEP (type): ________ Not Eligible: ______

Y0107_H2171_19_151_M