# 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 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, or pay a higher share of the cost.
- ☐ 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

- ☐ If you select a plan with a monthly premium then in addition to your monthly plan premium 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.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

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# Enrollment Request Form Guide

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

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 cnchealthplan.com/search.
- 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

- Complete a separate Enrollment Request Form for each person enrolling in a plan.
- Write your name exactly as it appears on your red, white, and blue Medicare card. This is how it will appear on your Care N' Care member identification card.
- **Double check** - Incomplete information may delay your enrollment.
- Remember, you must continue to pay your Medicare Part B Premium.

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

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## Return the Enrollment Request Form

- **Mail the completed Enrollment Request 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) <October 1 - March 31, 8am to 8pm, CST, seven days a week or April 1 - September 30, 8am to 5pm, CST, Monday through Friday>

# Individual Enrollment Request Form - 2020

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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:**

**MA-PD Plans:**

- ☐ Care N' Care Choice Premium PPO $200 per month
- ☐ Care N' Care Choice Plus PPO $55 per month
- ☐ Care N' Care Choice PPO $0 per month

**MA-Only Plan:**

- ☐ Care N' Care Choice MA-Only PPO $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.

# Individual Enrollment Request Form - 2020

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## 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.**

**You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) 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 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.)*

# Individual Enrollment Request Form - 2020

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## 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 1 to March 31, and 8 AM to 8 PM Monday through Friday, from April 1 to September 30. 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.

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, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Care N' Care provides refunds for all covered benefits, even if I get services out-of-network. 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:_____

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2020

## Individual Enrollment Request Form - 2020

# Attestation of Eligibility for an Enrollment Period

**Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year.** There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

- ☐ 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 am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ 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 recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date)_____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums, or I get Extra Help paying for Medicare prescription drug coverage, but I haven't had a change.
- ☐ 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). 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.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If one of these statements applies to you or you're not sure, please contact Care N' Care (HMO/PPO) at 1-877-665-2622 (TTY users should call 711) to see if you are eligible to enroll. We are open October 1- March 31, 8am to 8pm, CST, seven days a week or April 1- September 30, 8am to 5pm, CST, Monday through Friday