care@care
Insurance Company, Inc.

OMB No. 0938-1378
Expires 7/31/2023

Individual Enrollment Request Form

To Enroll In a Medicare Advantage Plan (Part C) Or Medicare Prescription Drug Plan (Part D)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Care N' Care Insurance Company, Inc.
1603 Lyndon B. Johnson Freeway, Suite 300
Farmers Branch, TX 75234

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Care N' Care at 1-877-905-9214. TTY userscan call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
En español: Llame a Care N' Care al 1-877-905-9214 /TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia enespañol y un representante estará disponible para asistirle.

Individuals experiencing homelessness.

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Y0107_23_007_C Approved

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Section 1 - All fields on this page are required (unless marked optional)

Select the plan you want to join:

- ☐ Care N' Care Choice Premium (PPO) H6328-001 $194 per month
- ☐ Care N' Care Choice Plus (PPO) H6328-002 $53 per month
- ☐ Care N' Care Choice (PPO) H6328-003 $0 per month
- ☐ Care N' Care Choice MA-Only (PPO) H6328-005 $0 per month
- ☐ Care N' Care Classic (HMO) H2171-001 $0 per month
- ☐ Southwestern Health Select (HMO) H2171-003 $0 per month

Optional Supplemental Benefits Rider:

- ☐ Care N' Care Dental Rider $25 per month

FIRST name:	LAST name:	Middle Initial:

Birth date: (MM/DD/YYYY)	Sex: ☐ Male ☐ Female	Phone number:

Permanent Residence street address (Don't enter a PO Box):

City:	County:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):
Street address: City: State: ZIP Code:

Your Medicare information:

Medicare Number:

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Care N' Care? ☐Yes ☐ No

Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage: _____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Care N' Care.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Care N' Care will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Care N' Care coverage begins, I must get all of my medical and prescription drug benefits from Care N' Care. Benefits and services provided by Care N' Care and contained in my Care N' Care "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Care N' Care will pay for benefits or services that are not covered.
- 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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 Medicare.

Signature:	**Today's Date:**

If you're the authorized representative, sign above and fill out these fields:

Name:	Address:
Phone Number:	Relationship to enrollee:

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Section 2 - All fields on this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or a Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ **I choose not to answer**

What's your race? Select all that apply.

☐ American Indian or Alaska Native
☐ Asian Indian
☐ Black or African American
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean
☐ Native Hawaiian
☐ Other Asian
☐ Other Pacific Islander
☐ Samoan
☐ Vietnamese
☐ White
☐ **I choose not to answer**

Select one if you want us to send you information in a language other than English. ☐ Spanish

Select one if you want us to send you information in an accessible format.
☐ Braille ☐ Large print ☐ Audio CD

Please contact Care N' Care at 1-877-905-9214 if you need information in an accessible format other than what's listed above. Our office hours are October 1 - March 31, 8am to 8pm, CST, seven days a week or April 1 - September 30, 8am to 8pm, CST, Monday through Friday. TTY users can call 711.

List your Primary Care Physician (PCP),clinic, or health center:_____
Note: For all HMO Plans, if a PCP is NOT provided, Care N' Care will automatically assign a PCP.

Your Medicare Part A Effective Date:_____
Your Medicare Part B Effective Date:_____

Are you enrolled in your State Medicaid program? ☐ Yes ☐ No
If yes, please provide your Medicaid number: _____

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):_____

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

I want to get the following materials via email. Select one or more:
☐ Annual Notice of Change (ANOC)
☐ Evidence of Coverage (EOC)
☐ Newsletter
☐ Member Alerts
E-mail address: _____

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Section 2 continued - All fields on this section are optional

Paying Your Plan Premiums

You can pay your monthly plan premium(including any late enrollment penalty that you currently have or may owe) by mail, online payment portal at cnchealthplan.com/members or Electronic Funds Transfer (EFT) each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Care N' Care the Part D-IRMAA.

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.)

Agent Information:
Name of agent/broker if assisted in enrollment:_____ NPN Number: _____
Effective Date of Coverage:_____ Date Application Received by Agent:_____
ICEP/IEP:_____ AEP:_____ SEP(type):_____ Not Eligible:_____

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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Discrimination is Against the Law

Care N' Care Health Plan (HMO/PPO) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Care N' Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Care N' Care:

- **Provides free aids and services to people with disabilities to communicate effectively with us, such as:**
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- **Provides free language services to people whose primary language is not English, such as:**
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Care N' Care at 1-877-665-2622 (TTY: 711), 8am to 8pm, CST seven days a week from October 1 – March 31, or 8am to 8pm, CST, Monday through Friday April 1 – September 30

If you believe that Care N' Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Care N' Care, Attn: Appeals and Grievances, 1603 Lyndon B. Johnson Freeway, Suite 300, Farmers Branch, TX 75234 , 1-877-665-2622 (TTY 711), or via fax at 817-810-5214.
You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Appeals and Grievances Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs. gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs. gov/ocr/office/file/index.html

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-374-7993 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-374-7993 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我┌提供免┌的翻┌服┌，┌助┌解答┌于健康或┌物保┌的任何疑 ┌。如果┌需要此翻┌服┌，┌致┌ 1-877-374-7993 (TTY: 711) 。我┌的中文工作人┌很┌意┌助┌。 ┌是一┌免┌服┌。

Chinese Cantonese: ┌對我們的健康或藥物保險可能存有疑問，┌此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-877-374-7993 (TTY: 711) 。我們講中文的人員將樂意┌┌提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-374-7993 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-374-7993 (TTY : 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-374-7993 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-374-7993 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-374-7993 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-374-7993 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إنن نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لديان. للحصول على مترجم فوري، ليس علينك سوى الاتصال بنا على 1-877-374-7993 (TTY: 711).
سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-374-7993 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-374-7993 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-374-7993 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-374-7993 (TTY : 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-374-7993 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: ┌社の健康 健康保┌と┌品 ┌方┌プランに┌するご質問にお答えするため に、無料の通┌サ┌ビスがありますございます。通┌をご用命になるには、1-877-374-7993 (TTY: 711)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサ┌ ビスです。

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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 my 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'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.

- ☐ 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 none of these statements applies to you or you're not sure, please contact Care N' Care (HMO/PPO) at 1-877-905-9214 (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.