

# 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](https://www.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 users can 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 en español 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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

### 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.**

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

**Select the plan you want to join:**

- |  |   |
|--|---|
| <input type="checkbox"/> Care N' Care Choice Premium (PPO) H6328-001 \$195 per month | <input type="checkbox"/> Care N' Care Classic (HMO) H2171-001 \$0 per month       |
| <input type="checkbox"/> Care N' Care Choice Plus (PPO) H6328-002 \$50 per month     | <input type="checkbox"/> Southwestern Health Select (HMO) H2171-003 \$0 per month |
| <input type="checkbox"/> Care N' Care Choice (PPO) H6328-003 \$0 per month           |   |
| <input type="checkbox"/> Care N' Care Choice MA-Only (PPO) H6328-005 \$0 per month   |   |

FIRST name: \_\_\_\_\_ LAST name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Birth date: (MM/DD/YYYY)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone number: 1
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Permanent Residence street address (Don't enter a PO Box): \_\_\_\_\_

City:	County:	State:	ZIP Code:
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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.

<b>Signature:</b> _____	<b>Today's Date:</b> _____
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**If you're the authorized representative, sign above and fill out these fields:**

Name: _____	Address: _____
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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: \_\_\_\_\_

**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](http://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.

# 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 1-877-374-7993 (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, 1-877-374-7993 (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:** 我們提供免費的翻譯服務，幫助解答關於健康或藥物保險的任何疑問。如果您需要此翻譯服務，請致電 1-877-374-7993 (TTY: 711)。我們的中文工作人員很樂意提供幫助。這是一項免費服務。

**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 pagsasalang-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamat. Upang makakuha ng tagasalang-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 quý vị cần thông dịch viên xin gọi 1-877-374-7993 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý 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 대해 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:** اني دلة وودألا لودج وأ ةحصلاب قلعتت ةلئسأ يأ نع ةباجلل ةي ن اجم ل ا يروف ل ا م جرت م ل ا م ادخ مدقن ان ان! ام صخش موقيس. 1-877-374-7993 (TTY: 711) على انب لاصتال ا وس كئيل ع سيل، يروف م جرت م ل ع لوصح لل ةي ن اجم ةمدخ هذ ه. كئ د ع ا س م ب ةي ب ر ع ل ا ث د ح ت ي.

**Hindi:** हमारे सुवास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएं 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こと質問にお答えするために、無料の通サービスがあります。通をご利用になるには、1-877-374-7993 (TTY: 711)にお電話ください。日本語を話す人が支援いたします。これは無料のサービスです。