MEDICARE ADVANTAGE
INDIVIDUAL ENROLLMENT ELECTION FORM

Step 1: Please fill out the application completely.
Use a ballpoint pen and press hard to make two copies.

Step 2: Sign and date the last page of the application.

Step 3: Keep the bottom yellow copy for your file.

If you have any questions regarding this application, please call:

Marketing Department: 1-800-847-1222
(TTY 711)
From October 1 through February 14, Marketing representatives will be available to answer your call from 8 a.m. to 8 p.m., seven days a week, except Thanksgiving and Christmas. From February 15 through September 30, Marketing representatives will be available to answer your call from 8 a.m. to 8 p.m., Monday through Friday, except holidays.

Care1st Health Plan
P. O. Box 4549
Montebello, CA 90640
www.care1stmedicare.com

Member Services: 1-800-544-0088
(TTY 711)
From October 1 through February 14, Member Services representatives will be available to answer your call from 8 a.m. to 8 p.m., seven days a week, except Thanksgiving and Christmas. From February 15 through September 30, Member Services representatives will be available to answer your call from 8 a.m. to 8 p.m., Monday through Friday, except holidays.

WHITE – Enrollment Copy YELLOW – Member’s Copy
H5928_15_004_EN Approved

2015 MEDICARE ADVANTAGE INDIVIDUAL ENROLLMENT ELECTION FORM

Please contact Care1st if you need information in another language or format (Braille).

To Enroll in Care1st, Please Provide the Following Information:

Care1st AdvantageOptimum Plan (HMO)

Area	Premium
☐ Los Angeles/Orange	$0/month
☐ San Joaquin	$29/month
☐ Stanislaus	$45/month
☐ San Bernardino/Riverside	$0/month
☐ San Diego	$0/month
☐ Santa Clara	$19/month
☐ El Paso	$0/month
☐ Alameda	$0/month
☐ Fresno	$0/month
☐ Merced	$0/month
☐ San Francisco	$29/month

Coordinated Choice Plan (HMO)

Area	Premium
☐ Los Angeles, Orange, San Diego, San Bernardino, Riverside, Santa Clara, Alameda, Fresno	$28.80/month*

Care1st TotalDual Plan (HMO SNP)

This plan is designed for people who meet specific enrollment criteria. You may be eligible to join this plan if you receive assistance from the State.

Area	Premium
☐ San Diego	$28.80/month*
☐ Los Angeles	$27/month*
☐ Alameda/San Francisco/ Santa Clara	$28.80/month*
☐ Orange/San Bernardino	$27.50/month*

**Premiums may vary based on the level of Extra Help you receive. Please contact the plan for further details.*

LAST Name: FIRST Name: Middle Initial: ☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date: ( ) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Home Phone: ( )	Alternate Phone Number: ( )

Permanent Residence Street Address (P.O. Box is not allowed): ____________________

City: ____________ State: ____ ZIP Code: __________ County: ____________

Mailing Address (only if different from your Permanent Residence Address):

Street Address: ____________________

City: ____________ State: ______ ZIP Code: ____________

Emergency contact:____________________

Phone Number: ____________ **Relationship to You:**____________

E-mail Address:

Please Provide Your Medicare Insurance Information.

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or Railroad Retirement Board.

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

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name:____________________

Medicare Claim Number Sex ______

___

Is Entitled To Effective Date

HOSPITAL (Part A) ____________

MEDICAL (Part B) ____________

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail 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 Care1st 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 coupon book.

Please select a premium payment option:

☐ Get a coupon book.

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (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.)

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 medical or drug coverage, including work, other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.
   Will you have other medical or prescription drug coverage in addition to Care1st? ☐ Yes ☐ No
   If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:
   Name of other medical coverage: ____________________ ID# for this medical coverage: ____________________ Group# for this medical coverage: ____________________
   Name of other drug coverage: ____________________ ID# for this drug coverage: ____________________ Group# for this drug 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 and 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), clinic or health center:

Physician's Name	ID Number	Medical Group / IPA Name

Are you an existing patient of this doctor? ☐ Yes ☐ No

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Care1st could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Care1st. 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:
Care1st 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. 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.

Care1st serves a specific service area. If I move out of the area that Care1st 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 Care1st, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Care1st 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 Care1st coverage begins, I must get all of my health care from Care1st, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Care1st and other services contained in my Care1st Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR Care1st WILL PAY FOR THE SERVICE.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Care1st, he/she may be paid based on my enrollment in Care1st.
Release of Information: By joining this Medicare health plan, I acknowledge that Care1st will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Care1st 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.

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format: ☐ Spanish ☐ Chinese ☐ Vietnamese

Contact us if you need a format like Braille, audiotape or large print.

Please contact Care1st at 1-800-544-0088 if you need information in another format or language than what is listed above. From October 1 through February 14, Member Services representatives will be available to answer your call from 8 a.m. to 8 p.m., seven days a week, except Thanksgiving and Christmas. From February 15 through September 30, Member Services representatives will be available to answer your call from 8 a.m. to 8 p.m., Monday through Friday, except holidays. TTY users should call 711.

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 a new Medicare beneficiary.
☐ I recently moved outside of the service are for my current plan or I recently moved and this plan is a new option for me.
I moved on ___ / ___ / ___ .
☐ I have both Medicare and Medi-Cal or my state helps pay for my Medicare premiums.
☐ I get Extra Help paying for Medicare prescription drug coverage.
☐ I no longer qualify for Extra Help paying for my Medicare prescription drugs.
I stopped receiving Extra Help on ___ / ___ / ___ .
☐ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home).
I moved/will move into/out of the facility on ___ / ___ / ___ .
☐ I recently left a PACE program on ___ / ___ / ___.
☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
I lost my coverage on ___ / ___ / ___ .
☐ I am leaving employer or union coverage on ___ / ___ / ___ .
☐ I belong to a pharmacy assistance program provided by my state or I am long/recently lost participation in such a program on ___ / ___ / ___ .
☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
☐ 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 ___ / ___ / ___ .

If none of these statements applies to you or you're not sure, please contact Care1st Health Plan at 1-800-544-0088, from 8:00 a.m. to 6:00 p.m., Monday through Friday. Between October 1 and February 14, representatives are available from 8:00 a.m. to 8:00 p.m., seven days a week. TTY users should call 711.

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:** ______________________________

Broker / Sales Use Only

Agent Name: ______________________________ Care1st Agent ID: ______________________________
Form Received On: ______________________________ Agent Phone/Email: ______________________________
Agent Signature: ______________________________ Date: ______________________________
Name of staff member/agent/broker (if assisted in enrollment): ______________________________
Effective Date of Coverage: ______________________________
☐ ICEP/IEP ☐ AEP ☐ SEP (type): ______________________ ☐ Not Eligible: ____________________

Care1st Enrollment Office Use Only

Confirmation ID:______________________________ Enrollee ID: ______________________________

WHITE – Enrollment Copy YELLOW – Member's Copy