OFFICE USE ONLY:
Received Date__________ Time _______
Enter Date___________ ES______
Submit Date__________ ES ______

315 SW Fifth Avenue, Suite 900
Portland, Oregon 97204
503-416-4100 or 800-224-4840
877-416-4161 (TTY/TDD)
Daily 8 am — 8 pm
www.careoregonadvantage.org

To Enroll in CareOregon Advantage, Please Provide the Following Information:

Please check which plan you want to enroll in:

☐ CareOregon Advantage Plus HMO SNP (You must have Medicaid and Medicare coverage to qualify for this plan).

☐ CareOregon Advantage Star HMO $26.40 premium.

☐ Mr. ☐ Mrs. ☐ Ms.	**Last Name:**	**First Name:**	**Middle Initial:**

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

Permanent Residence (street address only, P.O. Box is not allowed):

Street Address:

City:	State:	Zip Code:	County

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

Street Address:

City: State: Zip Code:

Emergency contact:

Relationship to You: **Phone Number:** ( )

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 the Social Security Administration or Railroad Retirement Board.

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

MEDICARE HEALTH INSURANCE

Name: ______________________________

Medicare Claim Number Sex____

___ ___ ___ - ___ ___ - ___ ___ ___ ___ ____

Is Entitled To	Effective Date
HOSPITAL (Part A)	______________
MEDICAL (Part B)	______________

Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No

If yes, what is the Diagnosis Date ____________________

If you have had a successful kidney transplant or no longer require a regular course of dialysis, please attach a note or records from your doctor showing you don't need dialysis or have had a successful kidney transplant.

2. Some individuals may have other health insurance and/or drug coverage, including other private insurance, TRICARE, employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.

Do you or your spouse work? ☐ Yes ☐ No

Will you have other <u>health</u> coverage <u>in addition</u> to CareOregon Advantage? ☐ Yes ☐ No
Will you have other <u>prescription drug</u> coverage <u>in addition</u> to CareOregon Advantage? ☐ Yes ☐ No

If yes, please list your other coverage and your identification (ID) number(s) for this coverage:

Type of coverage: ☐ Health ☐ Prescription drug Effective date: ____________

Name of other coverage:____ Phone: (   )

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: ___________________________________ Date of Admission: __________

Phone Number: __________________________

Address of Institution: ____

4. Are you enrolled in the Oregon Health Plan Medicaid program? ☐ Yes ☐ No
If yes, please provide your Oregon Health Plan ID number: _____________________________

5. Please indicate the name of your Primary Care Physician (PCP), clinic or health center :
First and Last Name or Clinic Name: ____
Established Patient: ☐ Yes ☐ No

6. 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 ☐ Vietnamese ☐ Russian ☐ Other (language or format): ________________________

Please contact CareOregon Advantage at 503-416-4100 or toll free at 1-800-224-4840, TTY/TDD users should call 1-877-416-4161. Our office hours are Monday through Friday, from 8 a. m. to 8 p. m.

Election Period Options

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you do not change your prescription drug coverage. Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods. In general, if you have both Medicaid and Medicare you may join a Medicare Advantage plan at any time during the year.

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 recently moved and this plan is a new option for me. Date of Move _____________

Previous Address ____

☐ I have both Medicare and Medicaid or my state helps pay for my Medicare Premiums.

☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on _____________

☐ I get extra help paying for Medicare prescription drug coverage.

☐ 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 drug coverage on _____________

☐ I am leaving employer or union coverage on _____________

☐ I belong to a pharmacy assistance program provided by my state.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S on _____________

☐ None of these statements applies to me.*

***Please contact CareOregon Advantage at 503-416-4100 or toll free at 1-800-224-4840, TTY/TDD users should call 1-877-416-4161 to see if you are eligible to enroll. Our office hours are Monday through Friday from 8 a. m. to 8 p. m.**

Paying Your Plan Premium

If you are enrolling in CareOregon Advantage HMO Star Plan and CMS determines that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay your late enrollment penalty and monthly premium by mail, Electronic Funds Transfer (EFT) or by automatic deduction from your Social Security Check each month.

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 does not cover.

Please select a premium payment option:
If you don't select a payment option, you will receive a bill each month.

☐ Receive a monthly bill

☐ Electronic funds transfer (EFT) from your bank account each month. (A CareOregon Advantage Easy Pay form must be completed and submitted for this option)

☐ Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment-effective date up to the point withholding begins).

Please Read This Important Information

If you currently have health coverage from an employer or union, joining CareOregon Advantage could affect your employer or union health benefits. If you have health coverage from an employer or union, joining CareOregon Advantage may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit its website, or contact the office listed in its communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign on Page 5:

By completing this enrollment application, I agree to the following:
CareOregon Advantage 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 only be in 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 CareOregon Advantage 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: November 15 – December 31 of every year) or under certain special circumstances. CareOregon Advantage serves a specific service area. If I move out of the area that CareOregon Advantage 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 CareOregon Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from CareOregon Advantage when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare

while out of the country except for limited coverage near the U.S. border. I understand that beginning on the date CareOregon Advantage coverage begins, I must get all of my health care from CareOregon Advantage, with the exception of emergency or urgently needed services or out-of-area dialysis services.

Services authorized by CareOregon Advantage and other services contained in my CareOregon Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **neither Medicare nor CareOregon Advantage will pay for the services.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with CareOregon Advantage, he/she may be compensated based on my enrollment in CareOregon Advantage.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information: By joining this Medicare Advantage health plan, I acknowledge that the Medicare Advantage health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that CareOregon Advantage 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 behalf of the individual under the laws of the state where the individual resides) 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 by CareOregon Advantage or by Medicare.

Your Signature:	**Today's Date:**

If you are the authorized representative (Power of Attorney, Responsible Party, Family Member), you must sign below and provide the following information:

Signature: ____ Date: ____________________

Name: ____ Phone Number: ______________

Address: ____

Relationship to Enrollee: ____

CareOregon Advantage Plan Use Only
Agent/Broker Name (if assisted with Enrollment): _____________________ Date ___________
Writing#: __________________
Effective Date of Coverage:__________________________

☐ ICEP/IEP ☐ OEP ☐ AEP ☐SEP (type): ___________