



# CareOregon Advantage

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 SNP (You must have Medicaid and Medicare coverage to qualify for this plan).
- CareOregon Advantage Star \$44.00 premium.

LAST name:	FIRST Name:	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
------------	-------------	----------------	---

Birth Date: (__ __ / __ __ / __ __ __ __) (M M / D D / Y Y Y Y)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number: (providing this information is optional)	Home Phone Number: (   )
---	--	---	-----------------------------

Permanent Residence Street Address: \_\_\_\_\_

City:	State:	Zip Code:
-------	--------	-----------

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

Street Address:	City:	State:	Zip Code:
-----------------	-------	--------	-----------

**Emergency contact:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Relationship to You** \_\_\_\_\_

## 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.



Name: \_\_\_\_\_

Medicare Claim Number \_\_\_\_\_ Sex \_\_\_\_\_

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Is Entitled To **HOSPITAL (Part A)** Effective Date \_\_\_\_\_

**MEDICAL (Part B)** \_\_\_\_\_

**Please read and answer these important questions:**

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

If you answered “yes” to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. Do you or your spouse work?  Yes  No

3. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to CareOregon Advantage?  Yes  No

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: \_\_\_\_\_

4. 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: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

5. Are you enrolled in your State Medicaid program?  Yes  No

If yes, please provide your Medicaid number: \_\_\_\_\_

**Please choose the name of a Primary Care Physician (PCP), clinic or health center (if required):**

**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:**

\_\_\_\_\_ Language A (e.g., Spanish)

\_\_\_\_\_ Language C (e.g., Vietnamese)

\_\_\_\_\_ Language B (e.g., Russian)

\_\_\_\_\_ Language D (e.g., Other) \_\_\_\_\_

Please contact CareOregon Advantage at 503-416-4100 or toll free at 1-800-224-4840, TTY users should call 1-877-416-4161. Our office hours are Monday through Friday from 8:00 a. m. to 5:00 p. m.

### Paying Your Plan Premium

If you are enrolling in CareOregon Advantage's Special Needs Plan and we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail, Electronic Funds Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security Check each month.

If you are selecting CareOregon Advantage's Star plan, You can pay your monthly premium by mail, Electronic Funds Transfer (EFT), or Credit Card each month. You can also choose to pay your premium by automatic deduction from your Social Security Check each month.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all of 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 bill

Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or deposit slip or provide the following:

Account holder name: \_\_\_\_\_

Bank routing number: \_\_\_\_\_ Bank account number: \_\_\_\_\_

Account type:  Checking  Saving

Credit Card: Please provide the following information:

Type of card: \_\_\_\_\_

Name of Account holder as it appears on card: \_\_\_\_\_

Account number: \_\_\_\_\_

Expiration Date: \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/YYYY)

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 their website, or contact the office listed in their 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 Below:**

**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 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 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: 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 health plan, I acknowledge that the Medicare 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, you must provide the following information:	
<b>Name :</b> _____	
<b>Address:</b> _____	
<b>Phone Number:</b> (____) ____ - ____	
<b>Relationship to Enrollee</b> _____	

<b>Office Use Only:</b> Name of staff member/agent/broker and ID number (if assisted in enrollment): _____ Plan ID #: _____ Effective Date of Coverage: _____ ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____
---