PLAN USE ONLY:

Received Date _____ Time _____

Enter Date _____ ES _____

Submit Date _____ ES _____

CareOregon Advantage

To enroll in CareOregon Advantage Plus HMO-POS SNP, please provide the following information:

☐ 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 Number:** ( ) ☐ 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:	County:

Emergency Contact:

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

Email Address:

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card

- OR -

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

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

Is Entitled To: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

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

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 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 Plus? ☐ Yes ☐ No

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

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: _____ Phone: _____

Address of Institution: _____

4. Are you enrolled in your State Medicaid (Oregon Health Plan) program? ☐ Yes ☐ No

If yes, please provide your Medicaid (Oregon Health Plan) number: _____

5. Do you or your spouse work? ☐ Yes ☐ No

6. Please choose the name of your Primary Care Physician (PCP), clinic or health center:

PCP First and Last Name: _____

PCP Clinic Location: _____

Clinic Name: _____ Established Patient: ☐ Yes ☐ No

7. Please check one of the boxes below if you would prefer us to communicate to you in a language other than English or in an accessible format: ☐ Spanish ☐ Vietnamese ☐ Russian ☐ Cantonese ☐ Mandarin ☐ Other (language or format): _____

Please contact CareOregon Advantage at 503-416-4279 or toll free at 888-712-3258 if you need information in an accessible format or language other than what is listed above. Our office hours are daily, from 8 a. m. to 8 p. m. TTY/TDD users should call 711.

8. How do you identify your ethnicity, tribal affiliation or ancestry?

☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ Decline to answer

9. Which of the following best describes your racial identity?

☐ American Indian or Alaska Native, non-Hispanic ☐ Asian, non-Hispanic ☐ Hispanic or Latino/a

☐ Black or African American, non-Hispanic ☐ Native Hawaiian or Pacific Islander, non-Hispanic

☐ White, non-Hispanic ☐ Unknown ☐ Decline to answer ☐ Other (please list): _____

Election Period Options

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between October 15 and 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 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 CareOregon Advantage at 503-416-4279 (toll free at 888-712-3258) to see if you are eligible to enroll.
We are open daily from 8 a. m. to 8 p. m. TTY/TDD users should call 711.

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. You could lose your employer or union health coverage if you join CareOregon Advantage. 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 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 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.

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 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 CareOregon Advantage coverage begins, I must get all of my health care from CareOregon Advantage, except for 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 paid based on my enrollment in CareOregon Advantage.

Release of Information: By joining this Medicare health plan, I acknowledge that CareOregon Advantage 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 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.

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

If you are the authorized representative, you must sign above and provide the following information:

Name: _____ Phone Number: _____

Address: _____

Relationship to Enrollee: _____

CareOregon Advantage Plan Use Only

Agent/Broker Name (if assisted with Enrollment): _____ Writing #:_____

Agent Received Date: _____

Effective Date of Coverage:_____

☐ ICEP/IEP ☐ AEP ☐ MAOEP ☐SEP (type): _____