



Please contact ConnectiCare, Inc. if you need information in another language or format.

To Enroll, Please Provide the Following Information:

Note to Applicant: For information about service area and premiums of *ConnectiCare Medicare Advantage* plans available to you, please refer to the Summary of Benefits. **Please check which plan you want to enroll in:**

- | | |
|---|--|
| <input type="checkbox"/> ConnectiCare Choice Plan 1 (HMO) | <input type="checkbox"/> ConnectiCare Flex Plan 1 (HMO-POS) |
| <input type="checkbox"/> ConnectiCare Choice Plan 2 (HMO) | <input type="checkbox"/> ConnectiCare Flex Plan 2 (HMO-POS) |
| <input type="checkbox"/> ConnectiCare Choice Plan 3 (HMO) | <input type="checkbox"/> ConnectiCare Flex Plan 3 (HMO-POS) |
| <input type="checkbox"/> ConnectiCare Passage Plan 1 (HMO) | |

Add Optional Supplemental Dental

LAST Name: _____ FIRST Name: _____ M.I.: _____ Mr. Mrs. Ms.

Birth Date: ____/____/____ Sex: M F Home Phone Number: () ____ - ____ Cell Phone Number: () ____ - ____

Email Address: _____

Permanent Residence Street Address (No PO Box): _____

City: _____ State: _____ ZIP Code: _____

Mailing Address (only if different from above): _____

City: _____ State: _____ ZIP Code: _____

Emergency Contact: _____ **Phone Number:** _____ **Relationship to You:** _____

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.

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or visit www.connecticare.com/medicare for additional payment options. 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 RRB. DO NOT pay ConnectiCare, Inc. the Part D-IRMAA.

(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.)

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 **800-772-1213**. TTY users should call **800-325-0778**. You can also apply for extra help online at **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 bill each month.**

Would you like the premium for this plan deducted from your SSA or RRB monthly benefit check?

Yes No

I get monthly benefits from: Social Security RRB

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 this plan? 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: _____

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 & Phone Number of Institution (number and street): _____

4. Are you enrolled in your State Medicaid program? ***(Required for enrollment in SNP Plans)**

Yes No If "yes," please provide your Medicaid number: _____

5. Do you or your spouse work? Yes No

6. Please choose the name of a Primary Care Physician (PCP) from our Provider Directory.

Name _____ PCP # _____ Current Patient

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format: Spanish Large Print

Please contact ConnectiCare at 1-877-224-8220, TTY: 711, 8 am to 8 pm, seven days a week from October 1 to March 31 and 8 am to 8 pm, Monday to Friday from April 1 to September 30, if you need information in an accessible format or language, other than what is listed above.

Please Complete This Section To Help Determine Which Election Period You Qualify For

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 please 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 enrolling during the Annual Enrollment Period (AEP) from October 15 to December 7.
- 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 ____/____/____.
- I recently was released from incarceration. I was released on ____/____/____.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ____/____/____.
- I recently obtained lawful presence status in the United States. I got this status on ____/____/____.
- I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on ____/____/____.
- 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 ____/____/____.
- 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 care facility). 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.
- 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 ____/____/____.
- 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 ____/____/____.
- 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.
- None of these statements apply to me.

If none of these statements applies to you or you're not sure, please contact ConnectiCare, Inc. at 1-877-224-8220 (TTY: 711), 8 am to 8 pm, 7 days a week from October 1 to March 31 and 8 am to 8 pm, Monday to Friday from April 1 to September 30, to see if you are eligible to enroll.



Please Read This Important Information

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

ConnectiCare, Inc. 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. If I am enrolling in the Choice Plan 2 (HMO), I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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.

ConnectiCare, Inc. serves a specific service area. If I move out of the area that these plans serve, 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 this plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from ConnectiCare, Inc. 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 ConnectiCare, Inc. coverage begins, I must get all of my health care from ConnectiCare, Inc., except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by ConnectiCare, Inc. and other services contained in

my ConnectiCare, Inc. Evidence of Coverage document (also known as a ConnectiCare, Inc. member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR CONNECTICARE, INC. WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with ConnectiCare, Inc., he/she may be paid based on my enrollment in ConnectiCare, Inc.

I understand that the phone numbers and/or email I provided on this application may be used by ConnectiCare, Inc. or any of its contracted parties to contact me about my account, my health benefit plan or related programs, or services provided to me.

Release of Information: By joining this Medicare health plan, I acknowledge that ConnectiCare, Inc. will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that ConnectiCare, Inc. 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:

Proposed Effective Date:

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:** _____

Staff Member/Agent/Broker Signature: _____ Agent/Broker ID#: _____

Date Accepted: _____ Source Code: _____ Location: _____

Election Period: ICEP/IEP: _____ AEP: _____ SEP (type): _____

Scope of Appointment (required if not seminar): Yes Seminar No Seminar

Please fax or mail the completed form (5 pgs) to:

ConnectiCare, Inc. & Affiliates
P.O. Box 4001
Farmington, CT 06034-9900
Fax: 1-800-871-5281

ConnectiCare, Inc. is an HMO/HMO-POS plan with a Medicare contract. Enrollment in ConnectiCare depends on contract renewal. ATTENTION: If you speak other languages, language assistance services, free of charge, are available to you. Call 1-877-224-8220 (TTY: 711). ATENCIÓN: Si usted habla otros idiomas, tiene a su disposición, gratis, servicios de ayuda para idiomas. Llame al 1-877-224-8220 (TTY: 711).