INSTRUCTIONS FOR COMPLETING YOUR CARESOURCE ENROLLMENT FORM

It's easy to enroll into a CareSource Medicare Advantage plan. To complete the Enrollment Form, simply follow these 5 steps.

If you are enrolling during the Annual Election Period, which runs from Oct. 15 through Dec. 7, we must receive your completed and signed Enrollment Form no later than Dec. 7 so your coverage can be effective Jan. 1.

If you are eligible to enroll at other times of the year, we must receive your completed and signed Enrollment Form no later than the end of the month to be effective the first of the following month.

CareSource is an HMO with a Medicare contract. Enrollment in CareSource Advantage® Zero Premium (HMO), CareSource Advantage® (HMO) and CareSource Advantage Plus® (HMO) depends on contract renewal.

Y0119_MA-M-0553-V.2 Approved

© 2017 CareSource. All rights reserved.

- [ ] **Step 1: Get your Medicare card**
  Before you start, take out your red, white, and blue Medicare card. Your Medicare card provides important information for completing the Enrollment Form.

- [ ] **Step 2: Complete your Enrollment Form**
  Please read the instructions and statements carefully. You must complete one Enrollment Form per person. If you have any questions, please call CareSource at **1-844-607-2830 (1-800-750-0750 or 711).** We are open 8 a.m. to 8 p.m. Monday through Friday, and from Oct. 1 – March 31, we are open the same hours seven days a week.

- [ ] **Step 3: Sign your Enrollment Form**
  Be sure to sign and date your Enrollment Form after you have completed every section. If you are the applicant's authorized representative, legal guardian, or power of attorney, please include a copy of the authorizing paperwork with the Enrollment Form. And don't forget, you must sign the Enrollment Form on behalf of the applicant.

- [ ] **Step 4: Complete the Attestation of Eligibility**
  Complete the Attestation of Eligibility in this section, which tells us you are able to enroll in Medicare.

- [ ] **Step 5: Submit your Enrollment Form and Attestation of Eligibility**
  After the application has been signed, please return the completed top white copy of each page of the enrollment form and the eligibility form. These can be mailed back to us at the following address:

  CareSource
  PO Box 1294
  Dept.: Enrollment
  Dayton, OH 45401-9903

  Don't forget to save a copy of the enrollment form for your records.

CareSource®
Health Care with Heart

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

To Enroll in CareSource Advantage® Zero Premium (HMO) / CareSource Advantage® (HMO) / CareSource Advantage Plus® (HMO), Please Provide the Following Information:

Please check which plan you want to enroll in:

CareSource Advantage Zero Premium	CareSource Advantage	CareSource Advantage Plus
$0 per month	$32.90 per month	$67.00 per month

LAST name:	FIRST name:	Middle Initial:	Mr. Mrs. Ms.

Birth Date: (_ _/_ _/_ _ _ _) (MM/DD/YYYY)	Sex: M F	Home Phone Number: ( ) -	Alternate Phone Number: ( ) -

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

City:	County:	State:	ZIP Code:

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

Street Address: ______________________________

City: ______________________ State: ____________ ZIP Code: ______________

E-mail 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

Top Copy – CareSource
Bottom Copy – Applicant

Paying Your Plan Premium

With the CareSource Advantage Zero Premium plan – If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you prefer to pay it. You can pay by mail, electronic check, credit card, debit card, or by phone each month or quarterly. 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 CareSource the Part-D IRMAA.

With the CareSource Advantage and CareSource Advantage Plus plans – You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, electronic check, credit card, debit card, or by phone 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 RRB. DO NOT pay CareSource 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 bill each month.

Please select a premium payment option:

Get a bill

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

I get monthly benefits from: ☐ Social Security ☐ RRB

(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, well 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 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 CareSource Advantage Zero Premium, CareSource Advantage or CareSource Advantage Plus? 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 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

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

____

Please check one of the boxes below if you would prefer us to send you information in an accessible format:

Spanish Large Print

Please contact CareSource at 1-844-607-2827 if you need information in another format or language than what is listed above. Our office hours are 8 a.m. to 8 p.m. Monday through Friday, and from October 1 through March 31 we are open the same hours 7 days a week. TTY users should call 1-800-750-0750 or 711.

Please Read this Important Information

If you currently have health coverage from an employer or union, joining CareSource Advantage Zero Premium, CareSource Advantage or CareSource Advantage Plus could affect your employer or union health benefits. You could lose your employer or union health coverage if you join CareSource. 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:

CareSource Advantage Zero Premium, CareSource Advantage, and CareSource Advantage Plus are Medicare Advantage plans and have 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: Oct. 15–Dec. 7 of every year), or under certain special circumstances.

CareSource serves a specific service area. If I move out of the area that CareSource 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 CareSource, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from CareSource 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 CareSource coverage begins, I must get all of my heath care from CareSource, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by CareSource and other services contained in my CareSource Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR CARESOURCE 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 CareSource, he/she may be paid based on my enrollment in CareSource.

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

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: ______________________________

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): ____________________

Plan ID #: ____

Effective Date of Coverage: ______________________________

ICEP/IEP:________AEP:__________SEP (type):____________________Not Eligible: ________

Agent/Broker Writing # or National Producer #: ______________________________

Agent Receipt Date: _______________________

CareSource is an HMO with a Medicare contract. Enrollment in CareSource Advantage Zero Premium® (HMO), CareSource Advantage® (HMO) or CareSource Advantage Plus® (HMO) depends on contract renewal.

Top Copy – CareSource
Bottom Copy – Applicant

P.O. Box 8738, Dayton, OH 45401-8738 | CareSource.com/Medicare

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 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 care 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 CareSource at **1-844-607-2827** (TTY users should call **1-800-750-0750**) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m. seven days a week from October 1 through March 31, and the same hours Monday through Friday the rest of the year.

CareSource - H6396

2019 Medicare Star Ratings*

The Medicare Program rates all health and prescription drug plans each year, based on a plan's quality and performance. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.
2. Summary Star Rating that focuses on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

For 2019, CareSource received the following Overall Star Rating from Medicare.

2.5 Stars

We received the following Summary Star Rating for CareSource's health/drug plan services:

Health Plan Services:	★★ 2 Stars
Drug Plan Services:	★★½ 2.5 Stars

The number of stars shows how well our plan performs.

★★★★★	5 stars - excellent
★★★★	4 stars - above average
★★★	3 stars - average
★★	2 stars - below average
★	1 star - poor

Learn more about our plan and how we are different from other plans at www.medicare.gov.

You may also contact us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time at 844-607-2830 (toll-free) or 800-750-0750 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

Current members please call 844-607-2827 (toll-free) or 800-750-0750 (TTY).

*Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.

Y0119_OHMA-M-0012_M

CareSource®

If you, or someone you're helping, have questions about CareSource, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-844-607-2827 TTY:711.

ARABIC
إذا كان لديك، أو لدى أي شخص تساعده، أية استفسارات بخصوص CareSource، فيحق لك الحصول على مساعدة ومعلومات مجانًا وباللغة التي تتحدث بها. للتحدث إلى أحد المترجمين الفوريين، اتصل على 1-844-607-2827 TTY:711.

AMHARIC
እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ CareSource ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-844-607-2827 TTY:711 ይደውሉ።

BURMESE
CareSource အကြောင်း သင် သို့မဟုတ် သင်အကူအညီပေးနေသူ တစ်စုံတစ်ယောက်က မေးမြန်းလာပါက သင်ပြောဆိုသော ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များအား အခမဲ့ ရယူနိုင်ရန် အခွင့်အရေးရှိပါသည်။ ဘာသာပြန်တစ်ဦးအား စကားပြောဆိုရန် 1-844-607-2827 TTY:711 ဤတွင် နံပါတ်ဖြည့်သွင်းပါ] သို့ ခေါ်ဆိုပါ။

CHINESE
如果您或者您在帮助的人对 CareSource 存有疑问，您有权免费获得以您的语言提供的帮助和信息。 如果您需要与一位翻译交谈，请致电 1-844-607-2827 TTY:711。

CUSHITE – OROMO
Isin yookan namni biraa isin deeggartan CareSource irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-844-607-2827 TTY:711 tiin bilbilaa.

DUTCH
Als u, of iemand die u helpt, vragen heeft over CareSource, hebt u het recht om kosteloos hulp en informatie te ontvangen in uw taal. Als u wilt spreken met een tolk, bel dan naar 1-844-607-2827 TTY:711.

FRENCH (CANADA)
Des questions au sujet de CareSource? Vous ou la personne que vous aidez avez le droit d'obtenir gratuitement du soutien et de l'information dans votre langue. Pour parler à un interprète, veuillez téléphoner au 1-844-607-2827 TTY:711.

GERMAN
Wenn Sie, oder jemand dem Sie helfen, eine Frage zu CareSource haben, haben Sie das Recht, kostenfrei in Ihrer eigenen Sprache Hilfe und Information zu bekommen. Um mit einem Dolmetscher zu sprechen, rufen Sie die Nummer 1-844-607-2827 TTY:711 an.

GUJARATI જો તમે અથવા તમે કોઈને મદદ કરી રહ્યાં તેમ ાંથી કોઈને CareSource વિશે પ્રશ્નો હોર તો તમને મદદ અને મ હહતી મેળિ નો અવિક ર છે. તે ખર્ચ વિન તમ રી ભ ષ મ ાં પ્ર પ્ત કરી શક ર છે. દ ભ વષર્ો િ ત કરિ મ ટે,આ 1-844-607-2827 TTY:711 પર કૉલ કરો.

HINDI
यदि आपके, या आप जिसकी मदद कर रहे हैं उसके CareSource के बारे में कोई सवाल हैं तो आपके पास बगैर किसी लागत के अपनी भाषा में सहायता और जानकारी प्राप्त करने का अधिकार है। एक दुभाषिए से बात करने के लिए कॉल करें, 1-844-607-2827 TTY:711.

ITALIAN
Se Lei, o qualcuno che Lei sta aiutando, ha domande su CareSource, ha il diritto di avere supporto e informazioni nella propria lingua senza alcun costo. Per parlare con un interprete, chiami il 1-844-607-2827 TTY:711.

JAPANESE
ご本人様、または身の回りの方で、CareSource に関するご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます（無償）。 通訳をご利用の場合は、1-844-607-2827 TTY:711 にご連絡ください。

KOREAN
귀하 본인이나 귀하께서 돕고 계신 분이 CareSource에 대해 궁금한 점이 있으시면, 원하는 언어로 별도 비용 없이 도움을 받으실 수 있습니다. 통역사가 필요하시면 다음 번호로 전화해 주십시오: 1-844-607-2827 TTY:711.

PENNSYLVANIA DUTCH
Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut CareSource, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-844-607-2827 TTY:711 uffrufe.

RUSSIAN
Если у Вас или у кого-то, кому Вы помогаете, есть вопросы относительно CareSource, Вы имеете право бесплатно получить помощь и информацию на Вашем языке. Для разговора с переводчиком, позвоните по номеру 1-844-607-2827 TTY:711.

SPANISH
Si usted o alguien a quien ayuda tienen preguntas sobre CareSource, tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, llame al 1-844-607-2827 TTY:711.

UKRAINIAN
Якщо у вас, чи в особи, котрій ви допомагаєте, виникнуть запитання щодо CareSource, ви маєте право безкоштовно отримати допомогу та інформацію вашою мовою. Щоб замовити перекладача, зателефонуйте за номером 1-844-607-2827 TTY:711.

VIETNAMESE
Nếu bạn hoặc ai đó bạn đang giúp đỡ, có thắc mắc về CareSource, bạn có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, vui lòng gọi số 1-844-607-2827 TTY:711.

 © 2016 CareSource. All Rights Reserved

CareSource complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status. CareSource does not exclude people or treat them differently because of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

CareSource provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified sign language interpreters, and (2) written information in other formats (large print, audio, accessible electronic formats, other formats). In addition, CareSource provides free language services to people whose primary language is not English, such as: (1) qualified interpreters, and (2) information written in other languages. If you need these services, please contact CareSource at 1-844-607-2827 TTY:711.

If you believe that CareSource has failed to provide the above mentioned services to you or discriminated in another way on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status, you may file a grievance, with:

CareSource
Attn: Civil Rights Coordinator
P.O. Box 1947, Dayton, Ohio 45401
1-844-539-1732, TTY: 711
Fax: 1-844-417-6254

CivilRightsCoordinator@CareSource.com

You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.