ConnectiCare

Employer/Union Group Health Plan

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

To Enroll in ConnectiCare, Inc., Please Provide the Following Information:

Employer or Union Name:		Group #:	
Please check which plan you want to enroll in: ☐ **High Option** ☐ **Low Option**			
Last Name:	First Name:	MI: ☐ Mr. ☐ Mrs. ☐ Ms.	
Birth Date: _____/____/____ MM / DD / YYYY	Gender: ☐ M ☐ F	Home Phone Number: (_____) _____ - _____	Cell Phone Number: (_____) _____ - _____
E-mail Address:		**Contact Preference:** ☐ Mail ☐ Email ☐ Text ☐ Phone	
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	State:	ZIP Code:	
Mailing Address (only if different from Permanent Residence Address): Street Address:	City:	State:	ZIP Code:
Medicare Number: _____ Part A _____/_____/_____ Part B _____/_____/_____			
I understand that the phone numbers and e-mail address I provided on this application may be used by ConnectiCare or any of its contracted parties to contact me about my account, the provision of services to me or my health benefit plan or related programs.			

Please Read and Answer These Important Questions

1. Are you the retiree? ☐ Yes ☐ No
   If yes, retirement date (month/date/year): _____
   If no, name of retiree: _____
2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No
   If yes, name of spouse: _____
   Name of dependents: _____
3. Do you or your spouse work? ☐ Yes ☐ No

Please Read and Answer These Important Questions (Continued)

4. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits, or State pharmaceutical assistance programs.

   Will you have other Prescription Drug Coverage in addition to ConnectiCare, Inc.?

   ☐ 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:

   _____ _____

Please choose the name of a Primary Care Provider (PCP).

Name:_____ PCP # _____ ☐ Current Patient

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format:

☐ Spanish ☐ Large Print

Please contact ConnectiCare at **877-224-8220** if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. to 8 p.m. ET, seven days a week. TTY users should call **711**.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer**

STOP Please Read This Important Information and Sign on Page 3

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 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. **It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. 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 if an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

Please Read This Important Information and Sign Below

ConnectiCare, Inc. serves a specific service area. If I move out of the area that ConnectiCare, Inc. 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 ConnectiCare, Inc., 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 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 e-mail address I provided on this application may be used by ConnectiCare or any of its contracted parties to contact me about my account, the provision of services to me or my health benefit plan or related programs.

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.

Please Sign Below

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

Proposed Effective Date:

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

Name: _____

Address: _____

Phone Number: (_____) _____ - _____

Relationship to Enrollee: ☐ Power of Attorney ☐ Guardian ☐ Conservator ☐ Other

For Company Use Only:

Staff Member/Agent/Broker Signature: _____ Date Accepted: _____

Plan ID #:_____ Agent/Broker ID: _____ Source Code: ☐ TM ☐ SEM ☐ SELF GEN

Election Period: ICEP/IEP:_____ AEP: _____ SEP (type): _____ Not Eligible: _____