



How To Enroll!

Enrollment Application Instructions

Please read before completing your enrollment request form.

You are eligible to join Care N' Care Health Plans PPO if:

- You are entitled to Medicare Part A and are enrolled in Part B;
- Do not have End Stage Renal Disease (ESRD)
- You live in Tarrant County, Johnson County (only zip codes 76036, 76028, 76063), or Parker County (only zip codes 76020, 76108, 76008, and 76126).

Please make sure you complete all necessary information on the enrollment request form and send all of the information to Care N' Care Health Plan PPO.

- 1.** Complete all sections of the application in full, including the plan you want to enroll in and your premium payment option. *Missing or incomplete information may cause delay in the effective date of your coverage.*
- 2.** If you are using a mailing address that is different from your permanent residential address, please indicate the name of the person and his/her address to which mail should be sent.
- 3.** When completing the Medicare insurance information, please write your name exactly as it appears on your Medicare card.
- 4.** Please choose the name of a Primary Care Physician (PCP).
- 5.** If you would prefer to receive information in a language other than English or in another format, be sure to check the box indicated.
- 6.** Your application must be signed, dated, and received by Care N' Care Health Plan PPO by the last calendar day of the month in order for your coverage to be effective the first day of the following month.
- 7.** Detach and keep the canary copy for your records. Send all remaining pages of the enrollment request form to Care N' Care Health Plan PPO in the enclosed postage paid envelope or mail to:

Care N' Care Health Plan PPO
Attn: Enrollment Department
1701 River Run, Suite 402
Fort Worth, TX 76107

Other Important Information

- If you have questions about your enrollment request form, please call us at 817-810-5213, TTY users call: 817-529-5268. A benefit consultant is available to help you seven days a week, 8 am to 8 pm. A benefit consultant will meet with you in-person to help you with your enrollment request form if you prefer.
- Care N' Care Health Plan PPO determines when your enrollment request form is considered to be complete based on Medicare enrollment guidelines.
- Your enrollment with Care N' Care Health Plan PPO is subject to approval by the Centers for Medicare & Medicaid Services (CMS). If your enrollment is not accepted by CMS, we will notify you immediately.
- Care N' Care is not a Medicare Supplement. By enrolling in one of our plans, you will remain a part of the Medicare program. Depending on which plan you select, you will have either Part C (MA-Only), which replaces Medicare Part A and Part B, or you will have Part C and Part D (MA-PD), which replaces Part A, Part B, and Part D (drug coverage).

Care N' Care Individual Enrollment Request Form

Please contact Care N' Care if you need information in another language or format

To Enroll in Care N' Care, Please Provide the Following Information:

Please check which plan you want to enroll in:

MA-PD Plans:

- Care N' Care Health Plan I PPO \$75 per month
- Care N' Care Health Plan II PPO \$29 per month
- Care N' Care Health Plan III PPO \$0 per month

MA-Only Plans:


- Care N' Care Health Plan V PPO \$30 per month
- Care N' Care Health Plan VI PPO \$0 per month

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	Home Phone Number: ()		Alternate Phone Number: ()
Permanent Residence Street Address (P.O. Box is not allowed):					
City:			State:	ZIP Code:	
Mailing Address (only if different from your Permanent Residence Address):					
City:			State:	ZIP Code:	
Emergency Contact:		Phone Number:		Relationship to You:	
E-mail Address:					

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 the Railroad Retirement Board.
- You must have Medicare Part A and Part B to join a Medicare Advantage plan.

MEDICARE			HEALTH INSURANCE	
SAMPLE ONLY				
Name: _____				
Medicare Claim Number			Sex _____	
_____ - _____ - _____				
Is Entitled To			Effective Date	
HOSPITAL (Part A)			_____	
MEDICAL (Part B)			_____	

Paying Your Plan Premium

If 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)" each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

You can pay your monthly plan premium by mail, "Electronic Funds Transfer (EFT)" each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

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 receive a payment book.

Please select a premium payment option:

- Receive a payment book
- Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:
- Account holder name: _____ Account type: Checking Saving
- Bank routing number: _____ Bank account number: _____
- 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 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. 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 Care N' Care? 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 (number and street):

Phone Number:

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

Please choose the name of a Primary Care Physician (PCP):

Please check the box below if you would prefer us to send your information in a language other than English or in another format:

Español

Please contact Care N' Care at 817-810-5213 (TTY users should call 817-529-5268) if you need information in another format or language than what is listed above. Our office hours are 8 am to 8 pm seven days a week.



Please Read This Important Information



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

Care N' Care 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. 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: November 15 - December 31 of every year), or under certain special circumstances.

Care N' Care serves a specific service area. If I move out of the area that Care N' Care 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 Care N' Care, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Care N' Care when I get it to know which rules I must follow in order 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 Care N' Care coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Care N' Care provides refunds for all covered benefits, even if I get services out of network. Services authorized by Care N' Care and other services contained in my Care N' Care Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR CARE N' CARE 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 Care N' Care, he/she may be paid based on my enrollment in Care N' Care.

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

Care N' Care Individual Enrollment Request Form

Signature: X		Today's Date:	
If you are the authorized representative , you must sign above & provide the following information:			
Name:		Address:	
Phone #:		Relationship to Enrollee:	
Office Use Only:			
Name of staff member/agent/broker (if assisted in enrollment):			
Plan ID #:		Effective Date of Coverage:	
<input type="checkbox"/> ICEP/IEP:	<input type="checkbox"/> OEP:	<input type="checkbox"/> OEP New:	<input type="checkbox"/> AEP:
<input type="checkbox"/> SEP (type):	<input type="checkbox"/> Not Eligible:		
Agent /Broker Name:		Agent /Broker ID #:	
Date Application Received by Agent:			