ConnectiCare

Enrollment Request for Passage Dual (HMO SNP)

2019

Please contact ConnectiCare Passage Dual if you need information in another language or format (Braille).

To enroll in the ConnectiCare Passage Dual (HMO SNP) plan, please provide the following information:

Please check the plan you want to enroll in. ☐ Passage Dual (HMO SNP)

Last Name:	First Name:	MI:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: _____/_____/_____ MM / DD / YYYY	Gender: ☐ M ☐ F	Home Phone Number: (__ __ __) __ __ __ - __ __ __ __	Primary Language:
E-mail Address:			
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	State:	ZIP Code:	
Mailing Address (only if different from Permanent Residence Address):			
City:	State:	ZIP Code:	
Emergency Contact:	Phone Number: (__ __ __) __ __ __ - __ __ __ __	Relationship to you:	

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 choose the name of a Primary Care Provider (PCP), clinic or health center:

Name:_____ PCP # _____ ☐ Current Patient

☐ I **don't** have a PCP. Please select a Passage PCP near _____ (Town/ZIP)

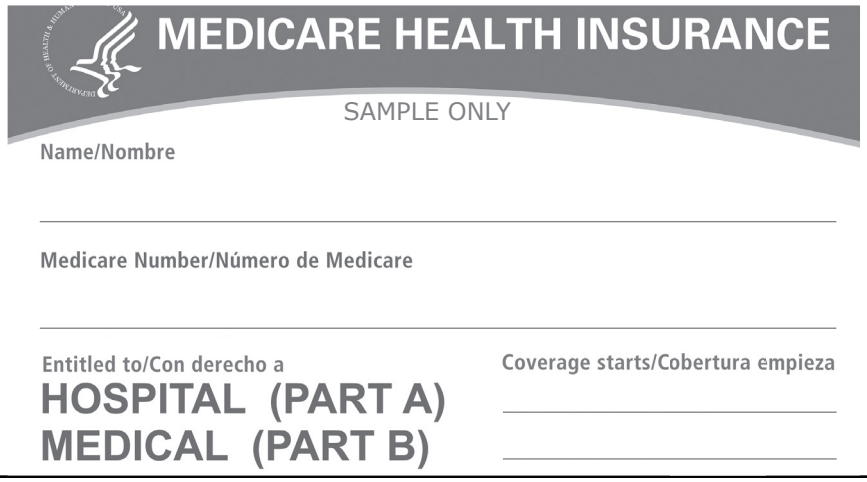
Note: To enroll in the Passage Dual plan, your PCP must be in the Passage network. If you do not select a PCP, one will be selected for you. At any time, you can select a different PCP in the Passage network.

Please Provide your Medicare Insurance Information

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

Please fill out this information as it appears on your Medicare card.

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



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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 ConnectiCare Passage Dual?

   ☐ 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 the CT State Medicaid program? ☐ Yes ☐ No

   If "yes", please provide your Medicaid number: _____

   You must be Dual eligible to join the ConnectiCare Passage Dual (HMO SNP) plan, which means you are enrolled in Medicare and receive full Medicaid (also known as Husky C, QMB+, or SLMB+) benefits.

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

☐ Spanish ☐ Large print

Please contact ConnectiCare at 1-877-224-8220 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 1-800-842-9710.

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 boxes to all of the statements that apply 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 ___ /___ /_____.

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Please Read and Answer These Important Questions (cont'd)

☐ 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 a 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.

If none of these statements applies to you or you're not sure, please contact ConnectiCare Passage Dual at 1-877-224-8220 (TTY: 1-800-842-9710) to see if you are eligible to enroll. Our office hours are 8 a.m. to 8 p.m. ET, seven days a week. TTY users should call 1-800-842-9710.

STOP Please Read This Important Information and Sign on Next Page

If you currently have health coverage from an employer or union, joining ConnectiCare Passage Dual could affect your employer or union health benefits. You could lose your employer or union health coverage if you join ConnectiCare Passage Dual. 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.

By completing this enrollment application, I agree to the following:
ConnectiCare Insurance Company, Inc. is an HMO SNP plan with a Medicare contract and a contract with the Connecticut Medicaid Program. Enrollment in ConnectiCare depends on contract renewal. 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: October 15 – December 7 of every year), or under certain special circumstances.

ConnectiCare Pasasge Dual serves a specific service area. If I move out of the area that ConnectiCare Passage Dual 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 Passage Dual, 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 Passage Dual when I get it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

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STOP Please Read This Important Information and Sign Below (cont'd)

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 Passage Dual coverage begins, I must get all of my health care from ConnectiCare Passage Dual except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by ConnectiCare Passage Dual and other services contained in my ConnectiCare Passage Dual Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR CONNECTICARE PASSAGE DUAL 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 Passage Dual, he/she may be paid based on my enrollment in ConnectiCare Passage Dual.

Release of Information: By joining this Medicare health plan, I acknowledge that ConnectiCare Passage Dual will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that ConnectiCare Passage Dual 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: ☐ Power of Attorney ☐ Guardian ☐ Conservator ☐ None

Race/Ethnicity (optional): ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other

Licensed Agent Use Only:

Agent/Broker Signature: _____ Date Accepted: _____

Agent/Broker ID: _____

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

A Scope of Appointment is required for all sales discussions except seminars.
Did this application originate at a seminar?

☐ YES ☐ NO

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