CareOregon Advantage

Individual enrollment request form

for CareOregon Advantage HMO-POS D-SNP,
a Medicare Advantage Plan with Part D Prescription Drug Coverage

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area.

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1).
- Within 3 months of first getting Medicare.
- In certain situations where you're allowed to join or switch plans.

Visit ***medicare.gov*** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items on pages 2 and 6. The items on pages 3, 4 and 5 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.

What happens next?

After you've completed all required pages of this form, sign it and send to:

CareOregon Advantage
315 SW Fifth Ave
Portland, OR 97204

Once we process your request to join, we'll contact you.

How do I get help with this form?

Call CareOregon Advantage at 888-712-3258. TTY users can call 711.

Or call Medicare at 800-MEDICARE (800-633-4227). TTY users can call 877-486-2048.

En español: Llame a CareOregon Advantage al 888-712-3258 (TTY: 711) o a Medicare gratis al 800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail, (e.g., Social Security checks) may be considered your permanent residence address.

To enroll in CareOregon Advantage Plus HMO-POS D-SNP, please provide the following information

(all fields on this page are required, unless marked with an "*")

Last name:	First name:	Middle initial:	
Birth date: (MM/DD/YYYY) / /	Sex: ☐ Male ☐ Female	Phone number: ( )	*Alternate phone number: ( )
Permanent residence street address:			
City:	*County:	State:	ZIP code:
Mailing address, if different from your permanent address (PO Box allowed):			

Your Medicare information:

Medicare number: _____

*Effective date: Part A _____

*Effective date: Part B _____

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to CareOregon Advantage Plus?

◯ Yes ◯ No If yes, name of other coverage: _____

Member number for this coverage: _____ Group number for this coverage: _____

Are you enrolled in your State Medicaid (Oregon Health Plan) program?

◯ Yes ◯ No If yes, please provide your Medicaid (Oregon Health Plan) number: _____

All fields in this section are optional

Please tell us a little more about yourself. Answering these questions is your choice. You can't be denied coverage because you don't fill them out. Any information you share will only be used to help us understand who joins plans for the purpose of reducing inequalities in certain groups.

IMPORTANT! Please choose the name of your Primary Care Physician (PCP), clinic or health center:

PCP first and last name: _____

PCP clinic location: _____

Clinic name: _____

Established patient: ☐ Yes ☐ No

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, another Hispanic, Latino/a, or Spanish origin
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ **I choose not to answer**

Preferred first name:

Preferred last name:

What are your preferred pronouns?

☐ He, him, his, himself ☐ She, her, hers, herself ☐ They, them, their, theirs, themselves
☐ Other pronouns ☐ Unknown pronouns

What is your gender identity?

☐ Transgender female ☐ Transgender male ☐ Non-binary
☐ Male ☐ Female ☐ Other ☐ I prefer not to disclose

What's your race? Select all that apply.

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

Please check one of the boxes below if you would prefer written communication in a language other than English:

☐ Russian ☐ Simplified Chinese ☐ Traditional Chinese ☐ Spanish
☐ Vietnamese ☐ Other language: _____

What language would you prefer for spoken communication?

Please specify if you prefer spoken communication in a language other than English:

Do you want to receive information from us in an accessible format?

☐ Large print ☐ Braille ☐ Audio CD

Please call CareOregon Advantage at 503-416-4279 or toll-free 888-712-3258, TTY 711, if you need information in an accessible format. Our office hours are October 1 through March 31, 8 a.m. to 8 p.m. daily; and April 1 through September 30, 8 a.m. to 8 p.m., Monday – Friday.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

Consent for electronic communication

I want CareOregon Advantage and others working on its behalf to send me information electronically. I give CareOregon Advantage permission to send me information and/or data including, but not limited to, alerts, required materials, and health-related benefit information. CareOregon Advantage may contact me by email, automated text and/or phone call. I understand that message and data rates apply. I acknowledge that I have the option to opt out of electronic communications at any time by contacting CareOregon Advantage at the number listed above.

My e-mail address: _____

My cell-phone number: _____

Attestation of eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between October 15 and 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.

Attestation of eligibility for an Enrollment Period — continued

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term 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 CareOregon Advantage at 503-416-4279 or toll-free at 888-712-3258, TTY 711, to see if you are eligible to enroll. Our hours are October 1 through March 31, 8 a.m. to 8 p.m. daily; and April 1 through September 30, 8 a.m. to 8 p.m., Monday – Friday.

PRIVACY ACT STATEMENT *The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.*

CareOregon Advantage Plan Use Only

Agent/Broker Name (if assisted with Enrollment): _____

Writing #: _____ Agent Received Date: _____ Effective Date of Coverage: _____

☐ ICEP/IEP ☐ AEP ☐ MAOEP ☐ SEP (type): _____

IMPORTANT: Read and sign below:

- I must keep both Part A and Part B to stay in CareOregon Advantage.
- **Release of information:** By joining this Medicare Advantage Plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that CareOregon Advantage 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. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA or Part D plan at a time - and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my CareOregon Advantage coverage begins, I must get all of my medical and prescription drug benefits from CareOregon Advantage. Benefits and services authorized by CareOregon Advantage and contained in my CareOregon Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor CareOregon Advantage will pay for benefits or services.**
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 Medicare.

Signature: _____ **Today's date:** _____

If you're the authorized representative, sign above and fill out these fields:

Name: _____

Phone number: _____

Address: _____

Relationship to enrollee: _____