CarePlus HEALTH PLANS

2026 Enrollment Form

Please follow these easy steps to become a CarePlus Medicare Advantage plan member.

Have your Medicare card ready

Please print clearly and fill out the entire form. Write the information exactly as it is on your Medicare card.
Each individual who applies must fill out a separate form.

Note: All fields that are both ***asterisked and underlined** are required. Non-required fields are optional. You cannot be denied coverage if you do not complete them.

Sign and date the Enrollment Form

This form is not complete until you sign it. If you do not complete and return this form on time, we may have to deny your enrollment. If someone is authorized to complete this form for you, they must sign it. This person must provide their legal proof of authorization if requested.

Please do not send multiple enrollment forms for the same plan and effective date.

If you have questions, please call the Member Services Department at **1-800-794-5907**. If you use a TTY, call **711**. We're available seven days a week, 8 a.m. - 8 p.m. However, please note that our automated phone system may answer your call on holidays and during weekends. For 24-hour service, visit us at **CarePlusHealthPlans.com**.

Read this important information

Before you sign, please read this entire Enrollment Form to make sure you understand the information provided.

Electronic enrollment options

Have you considered enrolling online at **CarePlusHealthPlans.com** instead?

It is a fast, secure, and easy way to apply.

You may **mail** this Enrollment Form to:

CarePlus Enrollment Forms
P.O. Box 14309
Lexington, KY 40512-4309

Or **fax** this Enrollment Form to: **877-889-9923**

Note: Please use the Fax Cover Sheet on the back of this page.

CarePlus
HEALTH PLANS™

Fax Cover Sheet

Date: _____

To: **CarePlus Enrollment**

Fax Number: **877-889-9923**

Number of Pages (Including Cover Sheet): _____

From (First and Last Name): _____

Agent ID # (SAN) – if completed by an agent: _____

Phone Number: _____

Fax Number: _____

Before you fax this Enrollment Form, please make sure all required fields (*asterisked and underlined) are completed clearly and legibly.

Message:

P.O. Box 14309, Lexington, KY 40512-4309

If you have questions, please call the Member Services Department at **800-794-5907**. If you use a TTY, call **711**. We're available seven days a week, 8 a.m. - 8 p.m. However, please note that our automated phone system may answer your call on holidays and during weekends. For 24-hour service, visit us at **CarePlusHealthPlans.com**.

Notice of Non-Discrimination

CarePlus Health Plans, Inc. complies with applicable Federal civil rights laws and does not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. CarePlus Health Plans, Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **800-794-5907 (TTY: 711)**. If you believe that CarePlus Health Plans, Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with CarePlus Health Plans, Inc. Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **800-794-5907 (TTY: 711)**, or **Accessibility1@CarePlus-HP.com**. If you need help filing a grievance, CarePlus Health Plans, Inc.'s Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for 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, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019, 800-537-7697 (TDD).**

CarePlus HEALTH PLANS™

This notice is available at **CarePlusHealthPlans.com/NDN**.

GHHNDN2026CP

Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available. Call **1-800-794-5907 (TTY: 711)**.

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسيق البديل مجانًا. اتصل على الرقم **1-800-794-5907 (الهاتف النصي: 711)**.

Հայերեն Armenian: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛ք՝ **1-800-794-5907 (TTY: 711)**:

বাংলা Bengali: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন **1-800-794-5907 (TTY: 711)** নম্বরে।

简体中文 Simplified Chinese：我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电 **1-800-794-5907（听障专线：711**）。

繁體中文 Traditional Chinese：我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電 **1-800-794-5907**（聽障專線：**711**）。

Kreyòl Ayisyen Haitian Creole: Lang gratis, èd oksilyè, ak lòt fòma sèvis disponib. Rele **1-800-794-5907 (TTY: 711)**.

Hrvatski Croatian: Dostupni su besplatni jezik, dodatna pomoć i usluge alternativnog formata. Nazovite **1-800-794-5907 (TTY: 711)**.

فارسی Farsi: خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **1-800-794-5907 (TTY: 711)** تماس بگیرید.

Français French : Des services gratuits linguistiques, d’aide auxiliaire et de mise au format sont disponibles. Appeler le **1-800-794-5907 (TTY: 711)**.

Deutsch German: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **1-800-794-5907 (TTY: 711)**.

Ελληνικά Greek: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **1-800-794-5907 (TTY: 711)**.

ગુજરાતી Gujarati: નિઃશુલ્ક ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **1-800-794-5907 (TTY: 711)** પર કૉલ કરો.

עברית Hebrew: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **1-800-794-5907 (TTY: 711)**

Hmoob Hmong: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **1-800-794-5907 (TTY: 711)**.

Italiano Italian: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiama il numero **1-800-794-5907 (TTY: 711)**.

This notice is available at CarePlusHealthPlans.com/MLI.

GHHNOA2025CP

日本語 Japanese:言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。**1-800-794-5907 (TTY: 711)** までお電話ください。

ភាសាខ្មែរ Khmer៖ សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ ទូរសព្ទទៅ លេខ **1-800-794-5907 (TTY: 711)**។

한국어 Korean: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다.
1-800-794-5907 (TTY: 711) 번으로 문의하십시오.

Diné: Saad t’áá jiik’eh, t’áadoole’é binahjį’ bee adahodooníígíí diné bich’į’ anídahazt’i’í, dóó ahgo át’éego bee hada’dilyaaígíí bee bika’aanída’awo’í dahólǫ. Kohjį’ hodíilnih **1-800-794-5907 (TTY: 711)**.

Polski Polish: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer **1-800-794-5907 (TTY: 711)**.

Português Portuguese: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue **1-800-794-5907 (TTY: 711)**.

ਪੰਜਾਬੀ Punjabi: ਮੁਫ਼ਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। **1-800-794-5907 (TTY: 711)** ‘ਤੇ ਕਾਲ ਕਰੋ।

Русский Russian: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру **1-800-794-5907 (TTY: 711)**.

Español Spanish: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y servicios en otro formato están disponibles. Llame al **1-800-794-5907 (TTY: 711)**.

Tagalog Tagalog: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **1-800-794-5907 (TTY: 711)**.

தமிழ் Tamil: இலவச மொழி, துணை உதவி மற்றும் மாற்று வடிவ சேவைகள் உள்ளன. **1-800-794-5907 (TTY: 711)** ஐ அழைக்கவும்.

తెలుగు Telugu: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **1-800-794-5907 (TTY: 711)** కి కాల్ చేయండి.

اردو Urdu: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال **(TTY: 711) 1-800-794-5907**

Tiếng Việt Vietnamese: Có sẵn các dịch vụ miễn phí về ngôn ngữ, hỗ trợ bổ sung và định dạng thay thế. Hãy gọi **1-800-794-5907 (TTY: 711)**.

Please read this important information

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

By completing this enrollment form, I agree to the following:

- I must keep both Medicare Hospital (Part A) and Medical (Part B) to stay in CarePlus.
- I understand that I can be enrolled in only one Medicare Advantage (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 and MA MSA plans).
- 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.
- This CarePlus plan serves a specific service area. If I move out of the area that this CarePlus plan serves, I need to notify CarePlus so I can disenroll and find a new plan. Emergency coverage (both within and outside the plan's service area) and urgent care are always covered.
- I understand that I must be a United States citizen or be lawfully present in the U.S.
- If you are requesting membership in a **Chronic Condition Special Needs Plan (C-SNP)**, the following statement applies: I understand this plan is a chronic condition special needs plan. My ability to enroll is based on physician verification that I have the qualifying medical condition(s).
- I understand that when my CarePlus coverage begins, I must get all my medical and/or prescription drug benefits from CarePlus. Benefits and services provided by CarePlus and contained in my CarePlus "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CarePlus will pay for benefits or services that are not covered. Benefits and services must be obtained from CarePlus in order to be covered as Medicare benefits, with the exception of hospice and kidney acquisition costs for transplants, which are covered by Medicare. I will abide by the rules of my Evidence of Coverage.
- Sales agents/brokers may be compensated if they are helping the applicant enroll.
- 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.

Release of Information: By joining this Medicare Advantage plan, I acknowledge that CarePlus will share my information with the U.S. Department of Health and Human Services (HHS), who may use it to track enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).

Privacy Act Statement: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 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.**

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 and used in the residential address field as your permanent residence address.

All *Asterisked and Underlined Fields Are Required *Proposed Effective Date (insert month): / 01 / 2026

Plan selection (please note all plans are not available in all markets).
*Please enter the plan information and select the corresponding plan name:

*Contract	*PBP	Segment
H 1 0 1 9		0 0

- ☐ CareAccess (HMO)
- ☐ CareBreeze (HMO C-SNP)[1]
- ☐ CareBreeze Platinum (HMO C-SNP)[1]
- ☐ CareComplete (HMO C-SNP)[1]
- ☐ CareComplete Platinum (HMO C-SNP)[1]
- ☐ CareFree Giveback (HMO)
- ☐ CareFree Platinum Giveback (HMO)
- ☐ CareNeeds Extra (HMO D-SNP)[2]
- ☐ CareNeeds Platinum (HMO D-SNP)[2]
- ☐ CareNeeds Plus (HMO D-SNP)[2]
- ☐ CareOne Plus (HMO)
- ☐ CareSalute (HMO)

[1]Qualifying chronic condition(s) required
[2]Applicable Medicaid eligibility required

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 (RRB).

Agent Name (Print): _____

Agent ID # (SAN): _____

MEDICARE HEALTH INSURANCE

***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 B to join a Medicare Advantage plan.

Member ID (For current or past CarePlus members)**:** _____

***Last Name:** _____ ***First Name:** _____ **Middle Initial:** ___

***Birth Date:** _____ (MM/DD/YYYY) ***Sex:** _____

It is important that we are able to reach you with the information you need to stay informed and take care of your health. Please provide your email address and telephone number.

Email Address: _____

By providing your email address, you authorize CarePlus to send you health information to this address.

Phone Number: _____ ☐ Home ☐ Cell ☐ Work ☐ Other

Alternate Phone Number: _____ ☐ Home ☐ Cell ☐ Work ☐ Other

There may be times when CarePlus will use an automated system to call or text you. When that happens, we will be sure to use the telephone number you provided.

Permanent Residence (P.O. Box ONLY allowed if experiencing homelessness)

***Street Address:** _____

***City:** _____ ***County:** _____ ***State:** _____ ***ZIP Code:** _____

Mailing Address (if different from your permanent residence)

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Please choose a Primary Care Physician (PCP), clinic, or health center:

PCP Name (print): _____ **PCP ID #:** _____

Are you already a patient of this PCP? ☐ Yes ☐ No

Paying your plan premium

If you selected a $0 premium plan and you owe a late enrollment penalty, you can pay by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you selected a plan with a monthly premium, you can pay this premium (and any late enrollment penalty) by mail or EFT each month. You can also pay your premium by having it automatically taken out of your Social Security or RRB benefit check each month.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (IRMAA), the Social Security Administration will notify you. You must pay this extra amount in addition to your plan premium.
DO NOT pay CarePlus the Part D-IRMAA.

If you do not select a premium payment option, you will get a coupon book.

Please select a premium payment option:

☐ Automatic deduction from your monthly Social Security or RRB benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

NOTE: Due to processing timelines required by Medicare, your Social Security or RRB deduction may be denied for your first premium payment. CarePlus will send you a paper bill for the initial payment and resubmit your request to Medicare for Social Security or RRB deduction to begin with your second month's premium. The deduction may take two or more benefit checks to begin. In most cases, if the SSA or RRB accepts your request for automatic deduction, the first deduction from your benefit check will start with the month that the SSA or RRB accepts your request. If the SSA or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

☐ Electronic Funds Transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

I authorize CarePlus to process premium payments (and any late enrollment penalty) from the following account. ☐ Checking ☐ Savings

Account Holder Name:

Depository Bank Name:

Bank Routing Number **Bank Account Number**

☐ Get a coupon book

Please read and answer these important questions:

1. **Once enrolled, will you have other medical health coverage?** ☐ Yes ☐ No
   If yes, complete the following:
   Carrier Name: _____
   Carrier Address 1: _____ Carrier Address 2: _____
   City: _____ State: _____ ZIP Code: _____
   Group # for this coverage: _____ ID # for this coverage: _____
   Are you the primary policy holder? ☐ Yes ☐ No
   Effective date of coverage: _____ Phone: _____

2. ***If you will have other prescription drug coverage (like VA or TRICARE) in addition to this plan, please check this box.** ☐ I will have other prescription drug coverage.
   Please provide your other prescription drug coverage details here, if applicable.
   Name of other coverage: _____ Phone : _____
   ID # for this coverage: _____ Group # for this coverage: _____

3. Are you enrolled in your State Medicaid Program? ☐ Yes ☐ No
   If yes, please provide your Medicaid number: _____

   Note: Applicable Medicaid eligibility is required when enrolling in a CareNeeds Extra (HMO D-SNP), CareNeeds Platinum (HMO D-SNP) or CareNeeds Plus (HMO D-SNP) plan.

4. If you are enrolling in CareComplete (HMO C-SNP) or CareComplete Platinum (HMO C-SNP), have you been diagnosed with and are currently being treated for diabetes, cardiovascular disorder, and/or chronic heart failure? ☐ Yes ☐ No

5. If you are enrolling in CareBreeze (HMO C-SNP) or CareBreeze Platinum (HMO C-SNP), have you been diagnosed with and are currently being treated for a chronic lung disorder? ☐ Yes ☐ No

6. Do you and/or your spouse work? ☐ Yes ☐ No

7. Please select one of the language preferences below:
   ☐ English ☐ Spanish ☐ Other: _____

8. If you need information in an accessible format, please select one of the options below. If none are selected, you will receive standard font, printed materials.
   ☐ Audio CD ☐ Large Print ☐ Accessible Screen Reader PDF ☐ Oral Over the Phone ☐ Braille
   ☐ Data CD
   Please contact Member Services at **800-794-5907 (TTY: 711)** if you need information in an accessible format or language other than what is listed above.

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period (**AEP**) from October 15 through December 7 of each year. In addition, you can choose to change your Medicare Advantage plan once during the annual Open Enrollment Period (**MA OEP**) between January 1 and March 31 of each year or immediately after enrolling in a plan during your Initial Enrollment Period/Initial Coverage Period (**OEP NEW**). Limitations on allowed plan changes during OEP apply. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods. Please read the following statements carefully and mark the bubble if the statement(s) applies to you. By marking any of the following bubbles 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.

	Code	Enrollment Period Statements
⬭	NEW	I just became eligible for Medicare Part A and/or Part B (ICEP/IEP).
⬭	LEC	I am leaving employer or union coverage on (***insert date**) _____.
⬭	AEP	I am enrolling during the Annual Enrollment Period.
⬭	CSN	I am enrolling in a Chronic Condition Special Needs Plan (C-SNP) that tailors its benefits to my chronic condition **OR** I was found to not have the qualifying condition after enrolling in a C-SNP and need to enroll in a different plan.
⬭	DIF	I was enrolled in a plan by Medicare (or my state) within the last 3 months and I want to choose a different plan.
⬭	NLS	I 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) within the last 3 months.
⬭	INC	I was released from incarceration within the last 3 months.
⬭	INT	I have both Medicare and full Medicaid benefits, and want to enroll into an integrated Dual Eligible Special Needs Plan. **Note: This SEP is valid once per month throughout each year, and only for enrollment into a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP), Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP), or Applicable Integrated Plan (AIP).**
⬭	LAW	I obtained lawful presence status in the United States within the last 3 months.
⬭	LCC	I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (***insert date**) _____. **Note: For Medicare Advantage Prescription Drug plans only.**
⬭	LTC	I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home). I moved/will move into/out of the facility on (***insert date**) _____.
⬭	MCD	I had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) within the last 3 months.

Continued on next page.

	Code	Enrollment Period Statements
⬭	MOV	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**__) _____.
⬭	EOC	My existing Medicare Advantage plan is non-renewing for the upcoming contract year. **Note: Only valid from December 8 through the last day of February of the following year.**
⬭	OEP	I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
⬭	PAC	I left a PACE (Program of All-Inclusive Care for the Elderly) program within the last 2 months.
⬭	RUS	I returned to the United States after living permanently outside of the U.S. within the last 3 months.
⬭	SNP	I am being disenrolled from a Special Needs Plan (SNP) because I no longer have special needs status **OR** I have been disenrolled from a SNP plan within the last 3 months.
⬭	OTH	None of the above statements apply to me; however, I feel I have a special circumstance which would allow me an exception to enroll (subject to approval). Please explain:

I have read and understand the important information on the preceding pages. I have reviewed and received a copy of the Summary of Benefits.

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

I understand that my signature (or the signature of the individual legally authorized to act on my behalf) on this enrollment form means that I have read and understand the contents of this enrollment form. If signed by an authorized representative (as described above), this signature certifies that: 1) this individual is authorized under State law to complete this enrollment, and 2) documentation of this authority is available upon request by Medicare.

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

Last Name: _____ First Name: _____

Relationship to Applicant: _____ Phone Number: _____

Address: _____

Please note that we require valid legal documentation of this authority to make healthcare decisions or inquiries concerning the applicant.

For individuals helping an applicant with completing this form only.

Complete this section if you are an individual (e.g. agents, brokers, SHIP counselors, family members, or other third parties) helping an applicant fill out this form.

Name: _____ Signature: _____

Relationship to Applicant: _____

National Producer Number (Agents/Brokers only): _____

For internal use by a licensed CarePlus sales agent

Sales Agent Name (Print): _____

Sales Agent Signature: _____

Sales Agent Email Address: _____

Sales Agent ID # (SAN): _____ **Date:** _____

Referring Agent Name: _____ Referring Agent #: _____

Ask the applicant: Would you like to provide your Veteran status?

☐ Self ☐ Spouse ☐ Dependent ☐ Not a Veteran ☐ Prefers not to answer

Lead Source:

☐ Book of Business ☐ Event ☐ Marketing/Advertisement ☐ Third-Party ☐ CarePlus

Scope of Appointment ID #: _____

Agents, please select one of the below indicating the appointment type:

☐ **F2F** – Face-to-Face

☐ **TEL** – Telephonic

☐ **RET** – Retail Partner

☐ **INH** – In-Home Appointment

☐ **OTH** – Other

☐ **SEM** – Seminar

☐ **WAL** – Walmart