

2027 Enrollment Form

Dual Eligible Special Needs Plan Enrollment Form

Use this form **ONLY** if you are enrolling into a CarePlus Dual Eligible Special Needs Plan.

Follow these easy steps to become a CarePlus Medicare member



Have both your Medicare and Medicaid cards ready

Each individual applying must fill out a separate form.



Sign and date the enrollment form

If the enrollment form is not completed and returned within the allotted time period, the enrollment could be denied.



Submit your enrollment form

You may fax the Member Services pages of this enrollment form to: **1-877-889-9923**. Or mail this enrollment form to:

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

Please don't send in the same enrollment form or apply to the same plan more than once.



Call us with questions

If you have questions, please call the Member Services Department at **1-800-794-5907 (TTY: 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 April 1 – September 30. Please leave your name and telephone number, and we'll call you back by the end of the next business day.



Electronic enrollment options

You may be able to enroll online. It's a fast, secure and easy way to apply. Visit **CarePlusHealthPlans.com** to see if electronic enrollment is available for the plan you'd like.

Instructions

- Completely fill the ovals.
- Use black ink only.
- Print only one clear number or capital block letter in each box.
- If you make a mistake, fix it by crossing out the box with an X. Put in the correct letter or number above or below the box as shown:

Correct numbers and letters

1 2 3 S M I ~~X~~ H

CarePlus
HEALTH PLANS

Additional Notes

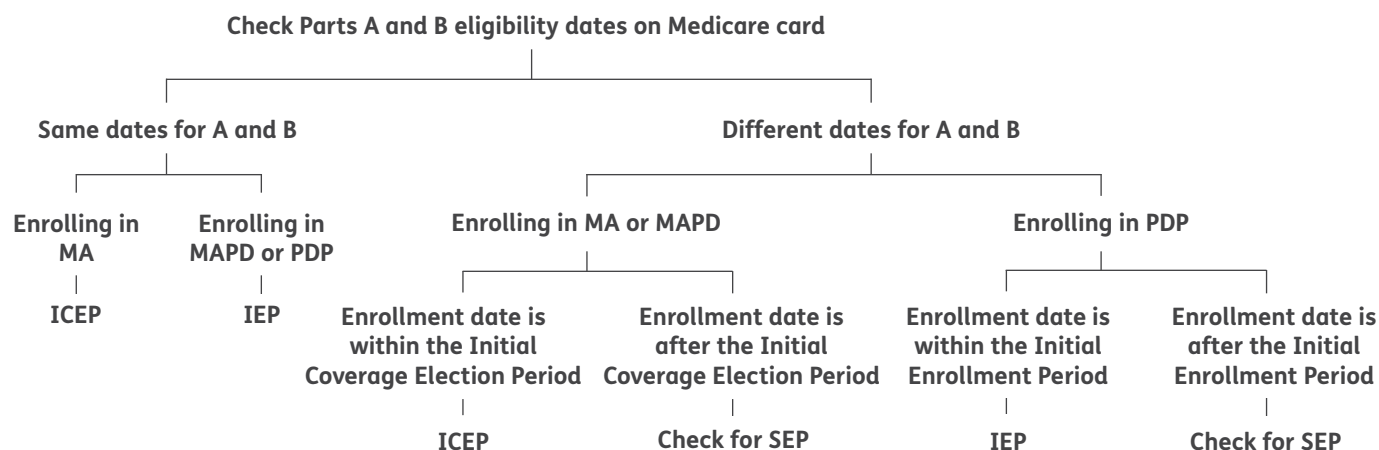
Asterisks (*) indicate required fields
Answering non-required fields is your choice. You can't be denied coverage if you don't complete them.

Initial Enrollment Period (IEP) and Initial Coverage Election Period (ICEP)

- If Part A and Part B dates are the same, the election period spans 7 months: 3 months prior to the month you become eligible, the month you become eligible, and 3 months after the month you became eligible.
- If Part A and Part B dates are different, the election period spans 5 months: 3 months prior to the month of the later effective date (often Part B), the month you become eligible, and 1 month after the month you become eligible. Only for enrollment into a Medicare Advantage (MA)-only plan or a Medicare Advantage prescription drug (MAPD) plan. If enrollment is for a prescription drug plan (PDP), check to see if the 7-month IEP may still be available.
- The coverage start date is based on factors such as Medicare entitlement and the submission of the completed enrollment form.

When inputting your Medicare Number on the enrollment form, print it exactly as it is on your Medicare card. N indicates a number, A indicates an alphabetic character, and E indicates either a number or alphabetic character. Medicare numbers will not start with a zero or contain the letters B, I, L, O, S or Z.

Enrollment periods may overlap. Ensure you mark any Special Election Period (SEP) oval that applies to you from the list of SEP statements on page 4 of the enrollment form. When enrolling specifically during an SEP, one of the SEP statements must be true to be eligible for an SEP. Agents, please refer to the Enrollment Options Job Aid (DMS-024) if you do not see the SEP listed on page 4.



Scope Of Appointment (SOA) (Page 7)

Agents, please use one of the three-letter codes below for the appointment type field.

F2F – Face to Face

INH – In Home Appointment

OTH – Other

RET – Retail Partner

SEM – Seminar

TEL – Telephonic

WAL – Walmart

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)**.



This notice is available at [CarePlusHealthPlans.com/NDN](https://www.CarePlusHealthPlans.com/NDN).

GHHNDN2026CP_0526

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 مجاناً. اتصل على الرقم **1-800-794-5907 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարեք **1-800-794-5907 (TTY` 711)** հեռախոսահամարով:

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]: Gen sèvis lengwistik gratis, èd oksilyè, ak lòt fòm sèvis ki disponib. Rele **1-800-794-5907 (TTY: 711)**.

Hrvatski [Croatian]: Dostupne su besplatne jezične usluge, usluge dodatne pomoći i 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 d'assistance linguistiques, d'aide auxiliaire et de format alternatif sont disponibles. Appelez le **1-800-794-5907 (ATS : 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]: મફત ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **1-800-794-5907 (TTY: 711)** પર ફોન 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. Chiamare il numero **1-800-794-5907 (TTY: 711)**.

GHHNOA2026CP_0526

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 សេវាកម្មជំនួយផ្សេងៗសម្រាប់អ្នកប្រើប្រាស់។ ទូរសព្ទទៅលេខ **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 [Navajo]: Saad bee áná'álwo', bee haz'áanii, dóó naaltsoos t'áa ajilíí'ígíí bee ak'e'elyaaígíí t'áa jik'eh hóló. **1-800-794-5907 (TTY: 711)** bich'í' hodíílnih.

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

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

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫਤ 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]: May available na mga libreng serbisyo sa wika, mga gamit na pantulong, at alternatibong format. Tumawag sa **1-800-794-5907 (TTY: 711)**.

தமிழ் [Tamil]: மொழி,, உதவிப் பொருட்கள் மற்றும் மாற்று வடிவமைப்புச் சேவைகள் இலவசமாகக் கிடைக்கின்றன. **1-800-794-5907 (TTY: 711)** எண்ணை அழைக்கவும்.

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

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

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

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



PLEASE READ THIS IMPORTANT INFORMATION

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

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

If I am enrolling in a Medicare Advantage health plan that has a contract with the federal government, I will need to keep my Medicare Parts A and B to stay in the plan. I must continue to pay my Medicare Part B premium. 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 Advantage health plan or prescription drug plan. It is my responsibility to inform CarePlus 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 my selected plan is generally for the entire year.

I understand that when my CarePlus coverage begins, I must get all of my medical and prescription drug benefits from CarePlus. Benefits and services provided by CarePlus and contained in my "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.

I understand that I must be a United States citizen or be lawfully present in the U.S. 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 in my new area. Emergency coverage (both within and outside the plan's service area) and urgent care are always covered.

I understand that a sales agent/broker may be compensated if they are helping me enroll.

Once CarePlus has received my enrollment form, I may get a verification letter to make sure that I understand how my plan works and to confirm my intent to enroll. This is not a secondary plan to Medicare Parts A and B. CarePlus pays instead of Medicare, and I will be responsible for the amounts that CarePlus doesn't cover, such as copayments and coinsurances. Medicare Parts A and B won't pay for my healthcare while I am enrolled in a Medicare Advantage health plan with CarePlus.

- If you are requesting membership in a **Dual Eligible Special Needs Plan (D-SNP)**, the following statement applies: I understand this plan is for individuals with both Medicaid and Medicare. My ability to enroll is based on verification that I am entitled to both Medicare and medical assistance under Medicaid.

For **FLORIDA** applicants of a D-SNP: I understand that this plan is sponsored by CarePlus and the State of Florida Agency For Health Care Administration.

- I understand that I am enrolling into a CarePlus Medicare Advantage plan and not a Medicare Supplement, Medigap, Medicare Select or Medicaid plan.

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 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 my 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, 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.**

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 benefit checks) may be considered and used in the residential address field as your permanent residence address.

Asterisks (*) indicate required fields

Typically, you may enroll in a Medicare Advantage or prescription drug plan during the Annual Election Period (AEP) between October 15 and December 7 of each year. In addition, you can choose to change your Medicare Advantage plan once during the annual Open Enrollment Period (OEP) between January 1 and March 31 of each year, or immediately after enrolling in a plan during your IEP/ICEP (OEP NEW). Limitations on allowed plan changes during OEP apply. There are exceptions that may allow you to enroll outside of these periods. Please read the following statements carefully and mark the oval to the left of any statement that applies to you. By marking any of the following ovals you are certifying that, to the best of your knowledge, the text is a true statement about you. **If we later determine that this information is incorrect, you may be disenrolled.**

SEP Code	Special Election Period (SEP) statements
☐ LEC	I am either losing/leaving coverage I had from an employer or union or lost this type of coverage within the last two months.
☐ NLS	I had a change in my Extra Help paying for Medicare prescription drug coverage (newly got assistance, had a change in level or lost eligibility) within the last three months.
☐ MCD	I had a change in my Medicaid status (newly got assistance, had a change in level or lost eligibility) within the last three months.
☐ MOV	I am moving or have moved within the last two months. The move is either outside the service area for my current plan or I have new options available to me.
☐ SNP	I have been notified that I no longer qualify for my Dual Eligible Special Needs Plan and am in a period of deemed continued eligibility or I was disenrolled from my Dual Eligible Special Needs Plan within the past three months due to a Medicaid change or loss.
☐ 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).
☐ EOC	My existing Medicare Advantage (MA) plan is ending its contract for the upcoming contract year. Note: This SEP is only valid from December 8 through the last day of February.
☐ OTH	None of the above statements apply to me. However, I feel I have a special circumstance which allows me an exception to enroll. CarePlus will contact you to determine if an exception can be granted. Must include the reason below.

Notes (if OTH):

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*
N A E N - A E N - A A N N

Plan selection

Please provide the plan information below for the medical plan you'd like.
Plan information can be found in your Summary of Benefits.

CONTRACT* PBP* SEGMENT
H 1 0 1 9 0 0

Please provide the base monthly premium for this plan from the Summary of Benefits. This amount helps us identify the plan you would like and should not include any late enrollment penalties or payments from other parties, like Medicaid.

BASE MONTHLY PREMIUM*
\$.

Select one option below corresponding with the plan details you provided above.
Refer to your Summary of Benefits or your agent for assistance.

I would like **ONE** of the following options:*

- ☐ CareNeeds Extra HMO D-SNP
- ☐ CareNeeds Plus HMO D-SNP
- ☐ CareNeeds Platinum HMO D-SNP

Medicaid eligibility is required for all Dual Eligible Special Needs Plans.

MEDICAID NUMBER

By marking this oval, I attest that I have received award materials for a future Medicaid effective date.

If you will have other prescription drug coverage (like VA, TRICARE) in addition to this plan for which you are applying, please fill this oval.*

☐ I will have other prescription drug coverage

Please provide your other prescription drug coverage details here, if applicable.

NAME OF OTHER COVERAGE

ID NUMBER FOR THIS COVERAGE

GROUP NUMBER FOR THIS COVERAGE

Once enrolled, will you or your spouse work? ☐ Yes ☐ No

Preferred Written Language (when available)

☐ English

☐ Spanish

☐ Chinese (Simplified)

☐ Chinese (Traditional)

☐ Korean

☐ Other

Preferred Verbal Language

☐ English

☐ Spanish

☐ Mandarin

☐ Cantonese

☐ Korean

☐ Other

If an accessible format is needed, please select one option. If none are selected, you will receive standard font, printed materials.

- ☐ Braille
- ☐ Large print (16 point +)
- ☐ Audio CD
- ☐ Data CD

Please call the Member Services Department at 1-800-794-5907 (TTY: 711) if you need information in another format or language.

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

N A E N - A E N - A A N N

PLEASE SELECT ONE PREMIUM PAYMENT OPTION. You may pay your monthly plan premium and/or late enrollment penalty via automatic deduction from your bank account, or Social Security Administration (SSA) or Railroad Retirement Board (RRB) benefit check. You may also choose to pay by mail using a coupon book. If you do not choose an automatic deduction option, or your automatic deduction request can't be processed, or you do not select any payment option, you will receive a coupon book with instructions for paying by mail.

☐

Automatic bank account deduction

Bank account information (Only complete this section if you selected Automatic bank account deduction as your payment option).

☐

Checking account

☐

Savings account

BANK NAME

ROUTING NUMBER

ACCOUNT NUMBER

FOR
001925097 213775710 186

Routing number

Account number

☐

Social Security benefit check deduction (Please see note below)

☐

Railroad Retirement Board benefit check deduction (Please see note below)

You must currently be receiving a Railroad Retirement Board benefit check in order to qualify for this payment option.

NOTE: Due to processing timelines mandated by Medicare, your first month's premium payment may not be deducted by SSA or RRB. If this occurs, CarePlus will attempt to start your SSA or RRB deductions for the earliest possible month and will send you an invoice for any months where SSA or RRB will not deduct your premiums. If accepted, it can take up to 3 benefit checks for SSA or RRB premium deductions to begin. If your deduction request is not accepted by Medicare, SSA or RRB, you will receive a coupon book with instructions for paying by mail or choosing another automatic deduction option.

☐

Coupon book

If you have selected coupon book as your payment option, you can pay as far in advance as you like.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. Do NOT pay CarePlus the Part D-IRMAA.

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

N A E N - A E N - A A N N

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

SIGNATURE OF APPLICANT* or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc.)

SIGNATURE DATE*

M M - D D - 2 0 Y Y

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), the 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 legal representative, you **MUST** sign above and provide the following information:*

LAST NAME

FIRST NAME

MI

STREET ADDRESS

CITY

ST

ZIP

TELEPHONE

RELATIONSHIP TO APPLICANT

FOR INDIVIDUALS HELPING AN APPLICANT WITH COMPLETING THIS FORM ONLY

Complete this section if you're 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)

AGENT USE ONLY

APPOINTMENT TYPE

SCOPE OF APPOINTMENT ID NUMBER

WRITING AGENT NAME*

AGENT NUMBER (SAN)*

DATE*

M M - D D - 2 0 Y Y

AFFINITY PARTNER CAMPAIGN

REFERRING AGENT NAME

REFERRING AGENT NUMBER (SAN)

CONTRACT*

H 1 0 1 9

PBP*

SEGMENT

0 0

Would you mind sharing whether you or your family ever served in the military?

☐ I served ☐ Spouse ☐ Dependent ☐ I have not served ☐ Prefers not to answer

LEAD SOURCE*

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



[CarePlusHealthPlans.com](https://www.CarePlusHealthPlans.com)