Clear Spring Health

Community Care Alliance of Illinois

Eon Health

Medicare Advantage Individual Enrollment Request Form

Section 1 – All fields on this page a e required (unless marked optional)

Eon Health

Who can use this form?

People with Medicare who want to join a Medicare Advantage 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 in Section 1. The items in Section 2 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.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Mail your completed and signed form to:

Eon Health
PO Box 278530
Miramar, FL 33027

Or

Fax your completed and signed form to:

1-866-341-2265
Attn: Eon Health
Enrollment Dept.

Or

Enroll online at:
www.eonhp.com

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

How do I get help with this form?

Call Eon Health at 1-877-364-4566. TTY users should call 711.
Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Eon Health al 1-877-364-4566/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

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Please contact Eon Health if you need information in an accessible language or format (Braille).

Eon Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

To enroll in an Eon Health Plan, please provide the following information:

Please refer to the service area charts on page 11 before completing. Check the plan you want to enroll in.

For Medicare beneficiaries who have Medica e Part A and enrolled in Medicare Part B-Medicare Advantage Prescription Drug Plan (MAPD):

South Carolina

- ☐ **Clear Spring Health Select Plan (HMO)**
  $0 premium per month (H9403-004)
- ☐ **Clear Spring Health Choice Plan (PPO)**
  $0 premium per month (H2334-003)
- ☐ **Clear Spring Health Gold Plus Plan (PPO)**
  $19 premium per month (H2334-005)

Georgia

- ☐ **Clear Spring Health Select Plan (HMO)**
  $0 premium per month (H6672-004)
- ☐ **Clear Spring Health Select Plus Plan (HMO)**
  $19 premium per month (H6672-005)
- ☐ **Clear Spring Health Choice Plan (PPO)**
  $0 premium per month (H9589-003)

For Medicare beneficiaries who also have Medicaid benefits receive assistance from the State – Dual Eligible Special Needs Plan (D-SNP):

South Carolina

- ☐ **Clear Spring Health Deluxe Plan (HMO D-SNP)**
  $0* premium per month (H9403-001)

Georgia

- ☐ **Clear Spring Health Deluxe Plan (HMO D-SNP)**
  $0* premium per month (H6672-001)

*Your costs may be as low as $0, depending on your level of Medicaid eligibility.

For Medicare beneficiaries living with diabetes, cardiovascula disorders or chronic heart failure – Chronic Condition Special Needs Plan (C-SNP):

South Carolina

- ☐ **Clear Spring Health Silver Plan (HMO C-SNP)**
  $0 premium per month (H9403-003)

Georgia

- ☐ **Clear Spring Health Silver Plan (HMO C-SNP)**
  $0 premium per month (H6672-003)

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Section 1 – All fields on this page a e required (unless marked optional)

Last Name: Middle Initial:

First Name:

Birth Date: (mm/dd/yyyy)

/ / Sex: ☐ Male ☐ Female

Primary Phone Number:

- -

Alternate Phone Number (Optional):

- -

Email Address (Optional):

Permanent Residence Street Address (P.O. Box is not allowed):

Address 2:

City: State: ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):

Address 2:

City: State: ZIP Code:

Emergency Contact (Optional):

Emergency Contact Phone Number: Relationship to You:

- -

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Section 1 – All fields on this page a e required (unless marked optional)

Your Medicare insurance information:

Medicare Number: ☐☐☐☐-☐☐☐-☐☐☐☐

Your Medicaid information:

This section is required only if applying for Clear Spring Health Deluxe. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If yes, please provide your Medicaid number: ☐☐☐☐☐☐☐☐☐☐☐☐

Chronic condition information

NOTE: This section is to be completed only if applying for Clear Spring Health Silver Plan. To be eligible for these Plans, you must have one of these conditions: Diabetes, Chronic Heart Failure (CHF), or Cardiovascular Disorder (CVD). Please answer the questions below.

☐ Yes ☐ No Have you ever been told by a doctor or clinic that you have diabetes (sugar)?

☐ Yes ☐ No Have you ever been told by a doctor or clinic that you have Congestive Heart Failure? (Such as fluid in the lungs or a weak heart)

☐ Yes ☐ No Have you ever been told by a doctor or clinic that you have Cardiac Arrhythmias? (An irregular heart beat or that your heart flutters or races)

☐ Yes ☐ No Have you ever been told by a doctor or clinic that you have Coronary Artery Disease? (Blocked arteries – had stents or heart bypass surgery – or a heart attack)

☐ Yes ☐ No Have you ever been told by a doctor or clinic that you have Peripheral Vascular Disease? (Poor blood flow to the legs; pain, burning or achiness in your legs when you walk, but goes away when you sit down)

☐ Yes ☐ No Have you ever been told by a doctor or clinic that you have Chronic Venous Thromboembolic Disorder? (Blood clots or are you taking Medicine for blood clots)?

Please read and answer these important questions:

1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to our Medicare Advantage Plan? ☐ Yes ☐ No

   If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage:

   ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

   Member ID # for this coverage: ☐☐☐☐☐☐☐☐☐☐

   Group # for this coverage: ☐☐☐☐☐☐☐☐☐☐

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Section 2 – All fields on this page are optional
Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

2. 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 of Institution (number and street):

   City: State: ZIP Code:

   Phone Number of Institution: ☐☐☐-☐☐☐-☐☐☐☐

3. Do you work? ☐ Yes ☐ No

4. Does your spouse work? ☐ Yes ☐ No

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Primary Care Physician (PCP) selection

HMO Only: Please choose the name of a Primary Care Physician (PCP), clinic or health center.

PCP Name:

PCP Address:

City: State: ZIP Code:

PCP Phone Number: - -

PCP Fax Number: - -

PCP #:

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

☐ Spanish ☐ Large Print ☐ Audio Tape ☐ Braille

Please contact Eon Health at (877) 364-4566 if you need information in an accessible format or language other than what is listed above. Our office hours are from October 1 – March 31, seven days a week, 8:00 a.m. – 8:00 p.m. and from April 1 – September 30, Monday through Friday, 8:00 a.m. – 8:00 p.m. (you may leave a voicemail Saturday, Sunday and Federal Holidays). TTY users should call 711.

Paying your plan premium and/or late enrollment penalty

Clear Spring Health Select Plan (HMO), Clear Spring Health Choice Plan (PPO), Clear Spring Health Silver Plan (HMO C-SNP), Clear Spring Health Deluxe Plan (HMO D-SNP): If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or "Electronic Funds Transfer (EFT)" each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Eon Health the Part D-IRMAA.

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Section 2 – All fields on this page are optional
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Clear Spring Health Gold Plus Plan (PPO), Clear Spring Health Select Plus Plan (HMO): You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or "Electronic Funds Transfer (EFT)" each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay Eon Health the Part D-IRMAA.

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 get a bill each month.

Please select a premium payment option:

☐ Get a bill

☐ Electronic funds transfer (EFT) from your bank account each month. Account type: ☐ Checking ☐ Saving

Account holder first name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Account holder last name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Bank routing number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Bank account number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.
I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Medicare Advantage Individual Enrollment Request Form

Please read this important information

If you currently have health coverage from an employer or union, joining an Eon Health MAPD plan could affect your employer or union health benefits If you have health coverage from an employer or union, joining an Eon Health MAPD plan may change how your current coverage works. 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 is no 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: Clear Spring Health has a contract with Medicare to offer PPO, HMO, and PDP Plans. Eon Health has a contract with the Georgia Medicaid program and a contract with the South Carolina Medicaid program. Enrollment in these plans depends on contract renewal. I will need to keep my 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 do not 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: October 15 – December 7 of every year), or under certain special circumstances.

Eon Health serves a specific service area. If I move out of the area that Eon Health 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 Eon Health, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Eon Health when I get it to know which rules I must follow 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.

HMO only: I understand that beginning on the date coverage begins, I must get all of my health care from Eon Health except for emergency or urgently needed services or out-of-area dialysis services.

PPO only: I understand that beginning on the date 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, Eon Health provides refunds for all covered benefits, even if I get services out of network.

Services authorized by Eon Health and other services contained in my Eon Health Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR EON HEALTH WILL PAY FOR THE SERVICES.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Eon Health he/she may be paid based on my enrollment in Eon Health.

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Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Eon Health 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 including the Statements of Understanding. 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 or by Medicare.

Signature: _____

Today's Date: ☐☐/☐☐/☐☐☐☐

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

First Name:

Last Name:

Address:

Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

Relationship to Enrollee:

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.

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For internal office use onl

To be filled out by staff member/agent/broker (if assisted in enrollment):

First Name:

Last Name:

Agent/Broker Writing Number:

Referring Agent Number:

Date Application Received by Agent/Broker: ☐☐/☐☐/☐☐☐☐

Proposed Effective Date: ☐☐/☐☐/☐☐☐☐

☐ **ICEP/IEP** ☐ **OEP** ☐ **AEP** SEP (type):

☐ **Not Eligible**

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Plans and Service Counties

Plans and Monthly Premium Costs	Service Counties
South Carolina	
Clear Spring Health Select Plan (HMO) $0 premium per month (H9403-004)	Beaufort, Chester, Colleton, Fairfield, Greenville, Hampton, Jasper, Lee, Saluda, Spartanburg, Union
Clear Spring Health Choice Plan (PPO) $0 premium per month (H2334-003)	
Clear Spring Health Gold Plus Plan (PPO) $19 premium per month (H2334-005)	
Clear Spring Health Deluxe Plan (HMO D-SNP) $0* premium per month (H9403-001)	
Clear Spring Health Silver Plan (HMO C-SNP) $0 premium per month (H9403-003)	
Georgia	
Clear Spring Health Select Plan (HMO) $0 premium per month (H6672-004)	Baker, Baldwin, Banks, Barrow, Bibb, Bleckley, Bryan, Butts, Chatham, Cherokee, Clayton, Clinch, Crawford, Dawson, DeKalb, Dodge, Dooly, Fayette, Forsyth, Franklin, Greene, Hancock, Hart, Heard, Henry, Houston, Jasper, Jones, Lamar, Lumpkin, Macon, Madison, McIntosh, Meriwether, Monroe, Morgan, Newton, Oconee, Oglethorpe, Peach, Pickens, Pike, Pulaski, Putnam, Rabun, Rockdale, Schley, Creven, Stephens, Talbot, Taliaferro, Taylor, Twiggs, Walton, White, Wilcox, Wilkinson
Clear Spring Health Select Plus Plan (HMO) $19 premium per month (H6672-005)	
Clear Spring Health Choice Plan (PPO) $0 premium per month (H9589-003)	
Clear Spring Health Deluxe Plan (HMO D-SNP) $0* premium per month (H6672-001)	
Clear Spring Health Silver Plan (HMO C-SNP) $0 premium per month (H6672-003)	

*Your costs may be as low as $0, depending on your level of Medicaid eligibility.