Clover Health Enrollment Form

Please contact Clover Health if you need information in another language or format (Braille).

Check which plan you want to enroll in:

- ☐ **Clover Health CarePoint $0.00 Premium** (Hudson County)
- ☐ **Clover Health Classic $0.00 Premium** (Atlantic, Bergen, Essex, Mercer, Monmouth, Passaic, Somerset, Union Counties)
- ☐ **Clover Health Prestige $178.00 Premium** (Bergen, Essex, Hudson, Monmouth, Somerset, Union Counties)
- ☐ **Clover Health Premier $40 Part D Premium** (Bergen, Essex, Hudson, Mercer, Passaic, Union Counties)

Please provide the following information:

LAST Name:	**Middle Initial:**	☐ Mr. ☐ Mrs. ☐ Ms.
FIRST Name:		

Birth Date: _____/_____/_____ (MM / DD / YYYY)	**Home Phone:** (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
Sex: ☐ Male ☐ Female	**Alternate Phone:** (Optional) (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Email Address:

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

City:	**County:**
State:	**Zipcode:**

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

City:	**County:**
State:	**Zipcode:**

Emergency Contact: (Optional)

Relationship:	**Phone:**

Please provide your Medicare Insurance Information:

Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Or use your Medicare card to complete this section. You must have Medicare Part A and Part B to join a Medicare Advantage Plan.

MEDICARE HEALTH INSURANCE

Name of Beneficiary:

Medicare Claim Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ - ___	**Sex:** ☐ M ☐ F

Hospital (Part A) Effective Date:
___ ___ - ___ ___ - ___ ___ ___ ___

Medical (Part B) Effective Date:
___ ___ - ___ ___ - ___ ___ ___ ___

Name: _____ Date: _____

Paying your Plan Premium Bill

You can choose from the following three options as monthly payment for your plan premium bill.

1. **Pay by check (direct billing):** You can write a check mailed to Clover every month.
2. **Automatic deduction from your Social Security Administration (SSA) or Railroad Retirement Board (RRB) benefit check:** Pay your premium and any Late Enrollment Penalty (LEP) you may owe by automatic deduction from your SSA or RRB benefit check each month.*

   *If you qualify for any of the New Jersey State Pharmaceutical Assistance Programs (SPAPs), please note the SSA does not interact directly with state subsidy programs. Therefore, it won't be aware that SPAP beneficiaries qualify for state-issued plan premium subsidies. If you are eligible for Medicaid or SPAPs, do not select automatic deduction from SSA as a payment option.
3. **Charge my bank account automatically each month:** Sign up for Electronic Funds Transfer (EFT) and your monthly premium can be automatically paid on a monthly basis (this includes any late enrollment penalty you have or may owe). EFT is safe, convenient, and saves you money on postage with no sign-up or transaction charges.

Your bill may contain the following components:

- Part C premium amount and/or Part D premium amount
- Part D Late Enrollment Penalty (LEP)
- Federal Subsidies
- State Subsidies
- Prescription Subsidies

Part C premium amount/Part D premium amount/ Part D Late Enrollment Penalty (LEP): Please be aware your plan may contain a Part C and/or Part D plan premium amount. You may also owe or currently have a Part D LEP and will be responsible for paying your LEP amount in addition to your plan premium. Contingent upon your payment option, you will either have the amount withheld from your SSA benefit check, RRB benefit check, or be billed by Clover. **DO NOT pay Clover Health the Part D-IRMAA.** If you are assessed for a Part D Income Related Monthly Adjustment Amount, such as a LEP, you will be notified by the SSA.

Federal Subsidies/Prescription Subsidies: People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, 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 won't have a coverage gap or a late enrollment penalty.

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, Clover will bill you for the amount that Medicare doesn't cover. 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: http://www.socialsecurity.gov/prescriptionhelp

State Subsidies: As a New Jersey resident, you may also qualify for State Pharmaceutical Assistance Programs (SPAPs). For more information, contact the NJ SPAP hotline at 1-800-792-9745 or visit http://www.state.nj.us/humanservices/doas/home/pbp.html

If you don't select a payment option, you will mailed a bill each month.

Please select a premium payment option:

☐ **Pay by check (direct billing).**

☐ **Automatic deduction from your monthly Social Security/ Railroad Retirement Board (RRB) benefit check.** (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.)

DO NOT check this box if you are eligible for Medicaid or State Pharmaceutical Assistance Programs (SPAPs).

Name: _____ Date: _____

Please select a premium payment option: (continued)
☐ **Charge my bank account automatically each month.** Once you have submitted an EFT form, it may take two or more months to take effect. You will receive a monthly paper bill until then. If you are interested in signing up for EFT, contact Clover Member Services at 1-888-657-1207 (TTY 711), 8am – 8pm EST, 7 days a week* if you need information.

Coordination of Benefits (other prescription drug coverage)	**Yes**	**No**
Will you receive other prescription drug coverage in addition to Clover Health plans? Some individuals may have additional prescription drug coverage, including other private insurance, TRICARE, Federal employee health benefits, VA benefits, or State Pharmaceutical Assistance Programs (SPAPs).	☐	☐

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:**

Coordination of Benefits (other medical coverage)	**Yes**	**No**
Do you or your spouse receive other medical coverage in addition to Clover Health plans? Some individuals may have additional medical coverage if they are still employed and on their employers' insurance plan or if receive disability insurance.	☐	☐

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:**

Coordination of Benefits (Long Term Care)	**Yes**	**No**
Are you a resident in a long-term care facility, such as a nursing home?	☐	☐

If "yes," please provide the following information:		
Name of Institution:		
Street Address:		
City:	**State:**	**Phone #:**

Please read and answer these important questions:	**Yes**	**No**
Do you have End Stage Renal Disease, or ESRD? 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.	☐	☐

*Clover Health is a Preferred Provider Organization (PPO) plan with a Medicare contract. Enrollment in Clover Health depends on contract renewal. Please call our Member Services at 1-888-657-1207 (TTY 711). From October 1 through February 14, our hours are from 8am – 8pm EST, 7 days a week. From February 15 through September 30, our hours are from 8am – 8pm EST, Monday – Friday. After hours and holidays, your call will be handled by our voicemail system. You can get this document in Spanish, or speak with someone about this information in other languages, for free.

Name: _____ Date: _____

Please read and answer these important questions: (continued)	**Yes**	**No**
Are you enrolled in your State Medicaid program? If yes, please provide your Medicaid number: __ __ __ – __ __ – __ __ __ __ – __	☐	☐
Do you or your spouse work?	☐	☐

Physician Selection

Please provide the name of your Primary Care Physician (PCP), clinic, or health center: (Optional)

Check the box that best describes your relationship to the person with Medicare listed on this form:

☐ I am the person listed on this enrollment form or I am simply helping to complete this enrollment form.	☐ I am the person authorized to act on behalf of the individual listed on this enrollment form under the laws of the State where the individual resides.

Check one of the following options to receive information in another language or format:

☐ Spanish	☐ Braille	☐ Audio Tape	☐ Large Print

If you need information in another language or format than what is listed above, please contact Clover at 1-888-657-1207 (TTY 711), 8am – 8pm EST, 7 days a week.*

Attestation of Eligibility for an Enrollment 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 moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) ____/____/_____
☐ I recently moved outside 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 left a PACE program on (insert date) ____/____/_____
☐ I recently was released from incarceration. I was released 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 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 am leaving employer or union coverage on (insert date) ____/____/_____
☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.	☐ I belong to a pharmacy assistance program provided by my state.

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Name: _____ Date: _____

Attestation of Eligibility for an Enrollment Period (continued)	
☐ I get extra help paying for Medicare prescription drug coverage.	☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help 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) ____/____/_____
If none of these statements applies to you or you're not sure, please contact Clover Member Services at 1-888-657-1207 (TTY 711), 8am – 8pm EST, 7 days a week* to see if you are eligible to enroll.	

If Hispanic/Latino ethnicity, please check all that apply (Optional)

☐ Mexican	☐ Mexican American	☐ Chicano/a	☐ Puerto Rican
☐ Cuban	☐ Other:		

Race, please check all that apply (Optional)

☐ White	☐ Black or African American	☐ Samoan	☐ Other:
☐ Chinese	☐ American Indian or Alaska Native	☐ Asian Indian	
☐ Filipino	☐ Other Pacific Islander	☐ Vietnamese	
☐ Japanese	☐ Native Hawaiian		
☐ Korean	☐ Guamanian or Chamorro		

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

Name:	
Street Address:	
Phone Number:	
Relationship to the Enrollee:	

Office Use Only:

Name of Staff member/agent/broker: (if assisted in enrollment)			
Agent/Broker ID #:		**Received Date:**	
Plan ID:		**Effective Date of Coverage:**	
ICEP/IEP:	**AEP:**	**SEP:** (type)	**Not eligible:**

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Name: _____ Date: _____

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

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.

Please read and sign below:

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

Clover Health is a Medicare Advantage plan and has a contract with the Federal government. 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.

Clover serves a specific service area. If I move out of the area that Clover 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 Clover, I have the right to appeal plan decisions about payment or services if I disagree. I will read Evidence of Coverage document from Clover 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.

I understand that beginning on the date Clover coverage begins, I must get all of my health care from Clover, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Clover provides refunds for all covered benefits, even if I get services out of network.

Services authorized by Clover and other services contained in my Clover Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR CLOVER 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 Clover, he/she may be paid based on my enrollment in Clover.

Release of Information: By joining this Medicare health plan, I acknowledge that Clover will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Clover 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.

SIGNATURE:	**TODAY'S DATE:**