Clover
2020 Tennessee Enrollment Form

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

Please check which plan you want to enroll in:

☐	**033 Clover Health Choice (PPO)**—$0 premium per month (Davidson, Rutherford, Williamson counties)
☐	**034 Clover Health Choice Value (PPO)**—$28.70 premium per month (Davidson, Rutherford, Williamson counties)

To enroll with Clover, please provide the following information:

First Name:	**Middle Initial:**	**Last Name:**

☐ Mr. ☐ Mrs. ☐ Ms.	**Birth Date (MM/DD/YYYY):** _____/_____/_____	**Sex:** ☐ Male ☐ Female

Home Phone Number: (_ _ _) _ _ _ - _ _ _ _	**Alternate Phone Number:** (_ _ _) _ _ _ - _ _ _ _

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

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

Mailing Address (only if different from your permanent residence address):

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

Email Address:

By providing your email address and phone number(s), you consent to receiving information related to your membership with Clover (e.g., benefit information), programs and services offered (e.g., health education materials, reminders), marketing and other communications (e.g., newsletters, surveys) electronically. Communications related to your membership with Clover or healthcare may include auto-dialed calls, pre-recorded or electronic voice messages, or text messages. You may opt out of these means of communication at any time by clicking the "opt out" link within any email message, or contacting Clover, or responding STOP to a text message. You may also request a hard copy of any material that Clover delivers electronically.

Name: _____ **Date:** _____

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 **You must have Medicare Part A and Part B to join a Medicare Advantage Plan.**	**Name** (as it appears on your Medicare card): **Medicare Number:** **Is Entitled to:** **Hospital (Part A)** Effective Date: _____ **Medical (Part B)** Effective Date: _____

Paying your Plan Premium:

☐ **You are enrolling in the Clover Health Choice (PPO) Plan with no monthly premium:**

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 Clover the Part D-IRMAA**.

☐ **You are enrolling in the Clover Health Choice Value (PPO) Plan with a monthly premium:**

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 the RRB. **DO NOT pay Clover the Part D-IRMAA**.

Name: _____ **Date:** _____

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 coinsurance. 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.

Please select a premium payment option:
If you don't select a payment option, you will get a bill each month.

☐ **Get a bill each month.**

☐ **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 late enrollment penalties 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.)

☐ **Electronic funds transfer (EFT) from your bank account each month.**

Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: _____ **Bank account number:** _____

Account type: ☐ Checking ☐ Saving

Name: _____ Date: _____

Please read and answer these important questions:		
1. 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.	Yes ☐	No ☐
2. Will you receive other <u>prescription</u> drug coverage in addition to Clover? Some individuals may have additional prescription drug coverage, including other private insurance, TRICARE, Federal employee health benefits, VA benefits, or State Pharmaceutical Assistance Programs. **If "yes," please list your other coverage and your identification (ID) number(s) for this coverage**	Yes ☐	No ☐
Name of other coverage:		
ID # for this coverage: / **Group # for this coverage:**		
3. Are you a resident in a long-term care facility, such as a nursing home? If "yes," please provide the following information:	Yes ☐	No ☐
Name of Institution:		
Street Address:		
City: / **State:** / **Phone #:**		
4. Are you enrolled in your State Medicaid program? If "yes," please provide your Medicaid number:	Yes ☐	No ☐
5. Do you or your spouse work?	Yes ☐	No ☐

Physician Selection
Please choose the name of a Primary Care Physician (PCP), clinic or health center:
Name: _____
Address: _____ Phone Number: _____
☐ I don't have a primary care physician, clinic, or health center. ☐ I don't know.

Clover Health is a Preferred Provider Organization (PPO) plan and a Health Maintenance Organization (HMO) plan with a Medicare contract. Enrollment in Clover Health depends on contract renewal. You must continue to pay your Medicare Part B premium.

Name: _____ Date: _____

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:	
Written: ☐ English ☐ Spanish	**Spoken:** ☐ English ☐ Spanish Other: _____
☐ Braille ☐ Audio Tape ☐ Large Print	
Please contact Clover at 1-888-657-1207 if you need information in an accessible format or language other than what is listed above. Our office hours are 8 am–8 pm local time, 7 days a week. Between April 1st and September 30th, alternate technologies (for example, voicemail) will be used on the weekends and holidays. TTY users should call 711.	

Please read this important information:

If you currently have health coverage from an employer or union, joining Clover 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 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.

Name: _____ Date: _____

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 the 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 US border.

I understand that beginning on the date Clover 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, 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 healthcare 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:**

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:**

Name: _____ Date: _____

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through 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 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 US. I returned to the US on (insert date) ____/____/_____
- ☐ I recently obtained lawful presence status in the US. 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.
- ☐ 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 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/losing 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 apply to you or you're not sure, please contact Clover to see if you are eligible to enroll at 1-877-618-8110 (TTY 711). We are open 8 am–8 pm, local time, 7 days a week. From April 1st through September 30th, alternate technologies (for example, voicemail) will be used on the weekends and holidays.