

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.

- | | |
|--|---|
| <ul style="list-style-type: none"><input type="checkbox"/> I am new to Medicare.<input type="checkbox"/> I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).<input type="checkbox"/> 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) ____/____/____<input type="checkbox"/> I recently was released from incarceration. I was released on (insert date) ____/____/____<input type="checkbox"/> I recently returned to the United States after living permanently outside of the US. I returned to the US on (insert date) ____/____/____<input type="checkbox"/> I recently obtained lawful presence status in the US. I got this status on (insert date) ____/____/____<input type="checkbox"/> 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) ____/____/____<input type="checkbox"/> 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) ____/____/____<input type="checkbox"/> 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. | <ul style="list-style-type: none"><input type="checkbox"/> 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) ____/____/____<input type="checkbox"/> I recently left a PACE program on (insert date) ____/____/____<input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) ____/____/____<input type="checkbox"/> I am leaving/losing employer or union coverage on (insert date) ____/____/____<input type="checkbox"/> I belong to a pharmacy assistance program provided by my state.<input type="checkbox"/> My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.<input type="checkbox"/> 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) ____/____/____<input type="checkbox"/> 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) ____/____/____<input type="checkbox"/> I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster. |
|--|---|

If none of these statements apply to you or you're not sure, please contact Clover Health 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.