Clever Care HEALTH PLAN

2025 Individual Enrollment Request Form

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?

Send your completed and signed form to:

Clever Care Health Plan
Attn: Enrollment Services
7711 Center Ave, Suite 100
Huntington Beach, CA 92647

Email: enrollment@ccmapd.com

Fax: (657) 276-4757

Once they process your request to join, they will contact you.

How do I get help with this form?

Call Clever Care at (833) 388-8168. TTY users can 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 Clever Care al (833) 388-8168/711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en Español y un representante estará disponible para asistirle.

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 checks) may be considered your permanent residence address.

Section 1

All fields on this page are required (unless marked optional)

Select the plan you want to join:

Clever Care **Longevity** (HMO) H7607-002

☐	001-Los Angeles County	$0 per month
☐	002-Orange County	$0 per month
☐	003-San Diego County	$0 per month
☐	004-San Bernardino County	$0 per month
☐	005-Riverside County	$0 per month

Clever Care **Value** (HMO) H7607-008

☐	001-Los Angeles County	$0 per month
☐	002-Orange County	$0 per month
☐	003-San Diego County	$0 per month
☐	004-San Bernardino County	$0 per month
☐	005-Riverside County	$0 per month

Clever Care **Total+** (HMO C-SNP) H7607-011

☐	001-Los Angeles County	$18.40 per month
☐	002-Orange County	$18.40 per month
☐	003-San Diego County	$18.40 per month
☐	004-San Bernardino County	$18.40 per month
☐	005-Riverside County	$18.40 per month

LAST name: _____

FIRST name: _____ **M.I.** (optional): ____

Birth date: M M / D D / Y Y Y Y **Sex:** ☐ Male ☐ Female

Phone Number: ( ) –

Permanent Residence Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

_____

City: _____ **State:** _____ **ZIP Code:** _____

Mailing Address, if different from your permanent address (PO Box allowed):

_____

City: _____ **State:** _____ **ZIP Code:** _____

Your Medicare information:

Medicare Number: _____ – _____ – _____

Based on Model of Care Review, Clever Care Health Plan, Inc., has been approved by the National Committee for Quality Assurance (NCQA) to operate a Chronic Special Needs Plan (C-SNP) through 2025.

Section 1

All fields on this page are required (unless marked optional) *continued*

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Clever Care? ☐ Yes ☐ No

Name of other coverage: _____

Member number for this coverage: _____ Group number for this coverage: _____

OPTIONAL:

Are you enrolled in your state Medi-Cal (Medicaid) program? ☐ Yes ☐ No

If "yes," please provide your Medi-Cal (Medicaid) number: _____

Complete only if you are enrolling in Clever Care Total+ (HMO C-SNP) plan

Have you been diagnosed with **diabetes** (high blood sugar) or are you taking insulin or other medications to control you blood sugar?	☐ Yes	☐ No
Have you been diagnosed with **cardiac arrhythmia** or atrial fibrillation (Afib) or have you had problems with rapid, irregular heartbeat?	☐ Yes	☐ No
Have you been diagnosed with **coronary artery disease (CAD)** or **peripheral vascular disease**, had a heart attack, or experienced poor circulation due to hardening of the arteries or veins?	☐ Yes	☐ No
Have you been diagnosed with **chronic venous thromboembolic disorder** or had blood clots in the veins more than once?	☐ Yes	☐ No
Are you taking medications to treat your conditions?	☐ Yes	☐ No

If yes, list the medications:

_____ _____ _____

Physician who can verify your condition(s)

Name: _____

Phone: (_____) _____ – _____ **Fax:** (_____) _____ – _____

Office Address:

_____

City: _____ **State:** _____ **ZIP Code:** _____

Authorization for Disclosure of Health Information

My signature authorizes the provider listed above and/or my PCP to disclose my health information and/or provide medical records to Clever Care Health Plan.

Section 1	**All fields on this page are required (unless marked optional)** *continued*

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Clever Care Health Plan.
- By joining this Medicare Advantage Plan, I acknowledge that Clever Care will share my information with Medicare, who may use it to track my enrollment, make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Clever Care Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Clever Care Health Plan. Benefits and services provided by Clever Care Health Plan and contained in my Clever Care Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Clever Care will pay for benefits or services that are not covered.
- 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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 Medicare.

Signature: _____ **Today's date:** M M / D D / Y Y Y Y

If you're the authorized representative, sign above and fill out these fields:

Name:	Address:
Phone number:	Relationship to enrollee:

Section 2

All fields on this page are optional

Answering these questions is your choice. You cannot be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin(1)
- ☐ Yes, Mexican, Mexican American, Chicano/a(2)
- ☐ Yes, Puerto Rican(3)
- ☐ Yes, Cuban(4)
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin(5)
- ☐ **I choose not to answer.**(6)

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native(1)
- ☐ Asian Indian(2)
- ☐ Black or African American(3)
- ☐ Chinese(4)
- ☐ Cambodian(5)
- ☐ Filipino(6)
- ☐ Guamanian or Chamorro(7)
- ☐ Japanese(8)
- ☐ Korean(9)
- ☐ Native Hawaiian(10)
- ☐ Other Asian(11)
- ☐ Other Pacific Islander(12)
- ☐ Samoan(13)
- ☐ Vietnamese(14)
- ☐ White(15)
- ☐ **I choose not to answer.**(16)

What is your preferred spoken language:

☐ English ☐ Mandarin ☐ Cantonese ☐ Khmer ☐ Korean ☐ Vietnamese ☐ Spanish
☐ Other: _____

What is your preferred written language, other than English?

☐ Chinese (traditional) ☐ Korean ☐ Vietnamese ☐ Spanish

Select one if you want us to send you information in an accessible format:

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Clever Care at (833) 388-8168 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week, from October 1 through March 31, and 8 a.m. to 8 p.m., weekdays, from April 1 through September 30. TTY users can call 711.

Do you work? ☐ Yes ☐ No **Does your spouse work?** ☐ Yes ☐ No

Texting and Email Opt-in:

Mobile phone number: (_____) _____ – _____

By providing my number, I agree to receive automated and/or other text messages by Clever Care Health Plan for healthcare, benefits, or any other purpose. Such consent is not a condition of receipt of any service and I can opt out at any time by calling Clever Care. Message and data rates may apply.

Email Address: _____

By providing my email address, I agree to receive Clever Care communications and materials electronically rather than by U.S. Mail. I understand this would include documents such as the Part C and Part D Explanation of Benefits (EOB), Annual Notice of Change (ANOC) and other materials. I can change back to U.S. mail at any time by calling Clever Care.

List your Primary Care Physician (PCP)

Name of PCP:

Medical Group or IPA:

PCP Enrollment ID #: _____ – _____

Are you a current patient of this PCP? ☐ Yes ☐ No ☐ I do not have a PCP, please assign one to me.

Section 3 Paying your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DO NOT pay Clever Care the Part D-IRMAA.

Please select a premium payment option. If you don't make a selection you will receive a bill.

- ☐ Get a bill.
- ☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from: ☐ i) Social Security ☐ ii) RRB

Thank you for choosing Clever Care Health Plan! (optional)

Please take a moment to share how you found Clever Care. Select one or more of the following examples:

- ☐ Television[1]
- ☐ Radio[2]
- ☐ Newspaper[3]
- ☐ Social media or computer (Google, Facebook, YouTube, Game app)[4]
- ☐ Mail[5]
- ☐ Family, friend, doctor, or acupuncturist[6]
- ☐ Your insurance broker[7]
- ☐ Event[8]
- ☐ Other:[9] _____

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name:	Relationship to enrollee:
Signature:	National Producer Number (Agents/Brokers only):
FMO (if applicable)	Telephonic Application?: ☐ Yes ☐ No
Effective date of coverage: M M / D D / Y Y Y Y	Date application was received: M M / D D / Y Y Y Y

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 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.

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 that 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.[1]
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).[2]
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on _____ / _____ / _____.[3]
- ☐ I recently was released from incarceration. I was released on _____ / _____ / _____.[4]
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on _____ / _____ / _____.[5]
- ☐ I recently obtained lawful presence status in the United States. I got this status on _____ / _____ / _____.[6]
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on _____ / _____ / _____.[7]
- ☐ 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 _____ / _____ / _____.[8]
- ☐ 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 _____ / _____ / _____.[9]
- ☐ I recently left a PACE® program on _____ / _____ / _____.[10]
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on _____ / _____ / _____.[11]
- ☐ I am leaving/losing employer or union coverage on _____ / _____ / _____.[12]
- ☐ I belong to a pharmacy assistance program provided by my state.[13]
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.[14]
- ☐ 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 _____ / _____ / _____.[15]
- ☐ 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 _____ / _____ / _____.[16]
- ☐ 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.[17]
- ☐ I want to join a Special Needs Plan that tailors its benefits to my chronic conditions.[18]

If none of these statements applies to you or you're not sure, please contact Clever Care at **(833) 388-8168 (TTY: 711)** to see if you are eligible to enroll.