Clever Care HEALTH PLAN

2026 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)	H7607-014-000	$0 per month
☐	Clever Care **Value** (HMO)	H7607-015-000	$0 per month
☐	Clever Care **Total+** (HMO C-SNP)	H7607-016-000	$0 per month
☐	Clever Care **Breathe+** (HMO C-SNP)	H7607-017-000	$0 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:

_____ – _____ – _____

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:

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 2026.

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

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)**, 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
Have you been diagnosed with **Peripheral Vascular Disease (PVD)** or experienced symptoms like leg pain when walking, foot numbness at night, non-healing leg sores, or coldness in one leg?	☐ Yes	☐ No
Have you been diagnosed with **Chronic Heart Failure (CHF)**, or do you often experience shortness of breath, fatigue, or swelling in your legs or ankles during daily activities or while lying down?	☐ Yes	☐ No

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

Have you been diagnosed with **asthma** or do you frequently experience wheezing, shortness of breath, chest tightness, or coughing, especially at night or after physical activity?	☐ Yes	☐ No
Have you been diagnosed with **chronic bronchitis** or do you have a persistent cough with mucus that lasts for at least three months in a year for two consecutive years?	☐ Yes	☐ No
Have you been diagnosed with **emphysema** or do you experience frequent shortness of breath, especially during physical activity, along with a chronic cough or wheezing?	☐ Yes	☐ No
Have you been diagnosed with **chronic obstructive pulmonary disease (COPD)** or often have shortness of breath, a chronic cough with mucus, or frequent wheezing?	☐ 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:**

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

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.

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.

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 ☐ 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.

F10001-LGP-EN (06/25)