RiverSpring Health Plans **ENROLLMENT REQUEST FORM**

SECTION 1 **All Fields on this page are required (unless marked optional)**
To Enroll in RiverSpring Health Plans, Please Provide the Following Information:

☐ RiverSpring Star (HMO I-SNP) $42.30 premium per month
☐ RiverSpring MAP (HMO D-SNP) $0.00 premium per month

Personal Information

Last Name: _____ First Name: _____

☐ Mr. ☐ Mrs. ☐ Ms. Sex: ☐ M ☐ F Middle Initial (optional): _____

Birth Date: (MM/DD/YYYY)
(__ __ / __ __ / __ __ __ __)

Home Phone Number: _____

Alternate Phone Number (optional): _____

E-mail Address (optional): _____

Permanent Residence

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

City: _____ County (optional): _____ State: _____ ZIP Code: _____

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

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

City: _____ County (optional): _____ State: _____ ZIP Code: _____

Emergency Contact

Name: _____

Phone Number: _____ Relationship to You: _____

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Name (as it appears on your Medicare card): _____

Medicare Number: _____

Is entitled to: Effective Date:

☐ Hospital (Part A): _____

☐ Medical (Part B): _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

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PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS:

1. Some individuals may have other drug coverage, including other private insurance, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

   Will you have other prescription drug coverage in addition to RiverSpring Health Plans?
   ☐ Yes ☐ No

   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: _____

2. Are you a resident of a long-term care facility, such as a nursing home?
   ☐ Yes ☐ No

   If "Yes," please provide the following information:

   Name of Institution: _____

   Address & Phone Number of Institution (number and street) _____

   _____

   _____

3. Please indicate if you meet all of the following requirements.

   You are eligible for full New York State Medicaid coverage
   ☐ Yes ☐ No

   You are 18 years or older
   ☐ Yes ☐ No

   You believe you are eligible for a nursing home level of care, are capable of safely remaining in your home, and require care management and home care or day care services for 120 continued days or longer?
   ☐ Yes ☐ No

4. Are you enrolled in your State Medicaid Program?
   ☐ Yes ☐ No

   If "Yes," please provide your Medicaid (CIN) number: _____

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IMPORTANT: PLEASE READ AND SIGN BELOW

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

- I must keep both Hospital (Part A) and Medical (Part B) to stay in RiverSpring Health Plans.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that RiverSpring Health Plans will share my information with Medicare, who may use it to track my enrollment, to 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.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my RiverSpring Health Plans coverage begins, I must get all of my medical and prescription drug benefits from RiverSpring Health Plans. Benefits and services provided by RiverSpring Health Plans and contained in my RiverSpring Health Plan's "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor RiverSpring Health Plans will pay for benefits or services that are not covered.
- 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: _____ Date: _____

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

Name: _____

Address: _____

Phone Number: _____

Relationship to Enrollee: _____

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PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS:

SECTION 2 Answering these questions is your choice. You can't be denied coverage because you don't fill them out. 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:

☐ Spanish
☐ Accessible Format (Braille, Audio or Large Print): _____

Please contact RiverSpring Health Plans at 1-800-771-0088 if you need information in an accessible format or language than what is listed above. Our office hours are 8 a.m. to 8 p.m. 7 days a week. TTY users should call 711.

Do you or your spouse work?
☐ Yes ☐ No

Please list your Primary Care Physician (PCP), clinic or health center:

Name: _____

Address: _____

PAYING YOUR PLAN PREMIUM

You can pay your plans premium (including any late enrollment penalty that you currently have or may owe) by Mail. 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.

Please select a premium payment option:

☐ Get a bill

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

I get monthly benefits from: ☐ Social Security ☐ RRB

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. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB).
DON'T pay (insert appropriate plan and/or organization name) the Part D-IRMAA.

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FOR RIVERSPRING HEALTH PLANS USE ONLY

Date Received: _____ Plan ID: _____

☐ QMB ☐ QMB+ ☐ SLMB ☐ SLMB+ ☐ QI-1 ☐ QDWI ☐FBDE

Name of Staff member (if assisted in enrollment): _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ OEPI: _____

Not Eligible: _____

LICENSED AGENT USE ONLY

I certify that I have truly and accurately recorded on this application the information supplied by the enrollee.

Licensed Agent: _____

Agent ID#: _____ Date Received: _____

Agent Signature: _____