COMPLETING THE ENROLLMENT FORM

Your Quick-Ref guide

You've made the sale! Now it's up to you to make sure the application's submission is flawless.

Each enrollment application is required to be:

1. Filled out legibly and completely to avoid denial or delays.
2. Submitted within 48 hours of your signature date (initial receipt date).
3. Accompanied by the following information and completed forms (if applicable):

- Cigna-HealthSpring Cover Sheet
- Statements of Understanding
- Necessary Chronic SNP forms
- Scope of Appointment
- Diabetic Verification
- Medicaid Verification
- Necessary Low Income forms

$ And always include your name and writing number—it's how you get paid!

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Completing the Application

Page 1

"Please select which plan you want to join"

Clearly mark **only one box** for the chosen benefit plan.

- Have Applicant initial any changes or errors and clearly mark out the erroneous information.
- Leave the monthly premium amount blank.
- Was the Encore Plan chosen? If so, check the box and fill in the monthly premium amount.

NOTE: When paying premiums for our Encore Plan, the applicant can't use LIS, SPAP, or Social Security.

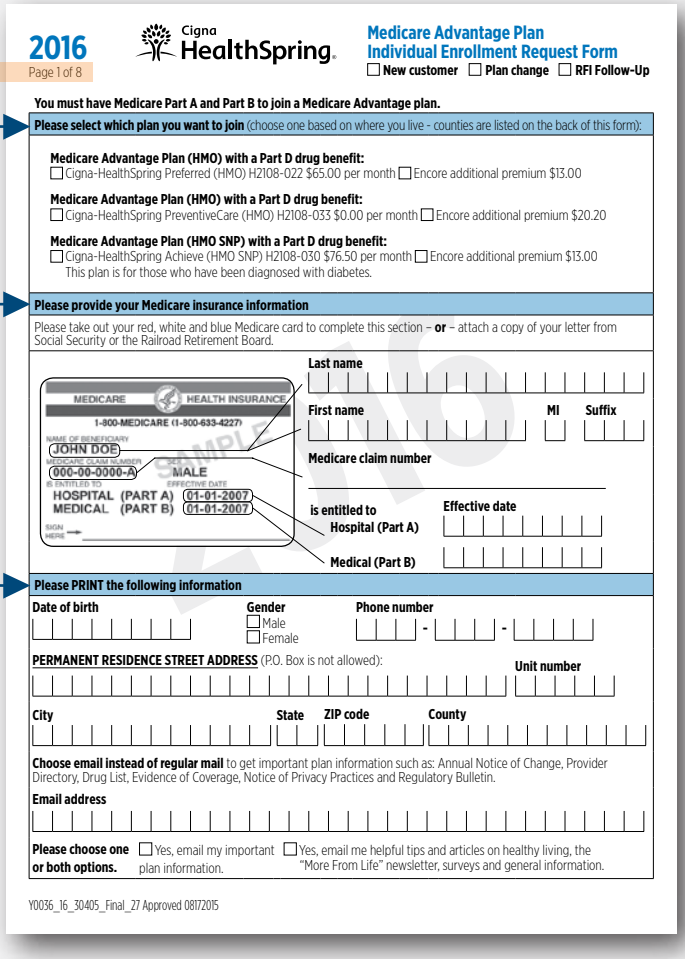
"Please provide your Medicare insurance information"

If only an Eligibility Letter is available, copy it and attach to the application.

"Please PRINT the following information"

Complete each box and include the Mailing Address in the next section if it's different from the Permanent Address.

- P.O. Box numbers are permitted only in the Mailing Address section--not the Permanent Address section.
- The applicant must live in the service area covered by their new benefit plan.



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Cigna HealthSpring

Medicare Advantage Plan Individual Enrollment Request Form

☐ New customer ☐ Plan change ☐ RFI Follow-Up

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

Please select which plan you want to join (choose one based on where you live - counties are listed on the back of this form):

Medicare Advantage Plan (HMO) with a Part D drug benefit:
☐ Cigna-HealthSpring Preferred (HMO) H2108-022 $65.00 per month ☐ Encore additional premium $13.00

Medicare Advantage Plan (HMO) with a Part D drug benefit:
☐ Cigna-HealthSpring PreventiveCare (HMO) H2108-033 $0.00 per month ☐ Encore additional premium $20.20

Medicare Advantage Plan (HMO SNP) with a Part D drug benefit:
☐ Cigna-HealthSpring Achieve (HMO SNP) H2108-030 $76.50 per month ☐ Encore additional premium $13.00
This plan is for those who have been diagnosed with diabetes.

Please provide your Medicare insurance information

Please take out your red, white and blue Medicare card to complete this section – **or** – attach a copy of your letter from Social Security or the Railroad Retirement Board.

MEDICARE HEALTH INSURANCE
1-800-MEDICARE (1-800-633-4227)
NAME OF BENEFICIARY JOHN DOE
MEDICARE CLAIM NUMBER 000-00-0000-A
SEX MALE
IS ENTITLED TO HOSPITAL (PART A) 01-01-2007
MEDICAL (PART B) 01-01-2007
EFFECTIVE DATE
SIGN HERE

Last name
First name MI Suffix
Medicare claim number
is entitled to Hospital (Part A) Effective date
Medical (Part B)

Please PRINT the following information

Date of birth
Gender ☐ Male ☐ Female
Phone number
PERMANENT RESIDENCE STREET ADDRESS (P.O. Box is not allowed):
Unit number
City State ZIP code County

Choose email instead of regular mail to get important plan information such as: Annual Notice of Change, Provider Directory, Drug List, Evidence of Coverage, Notice of Privacy Practices and Regulatory Bulletin.

Email address

Please choose one or both options. ☐ Yes, email my important plan information. ☐ Yes, email me helpful tips and articles on healthy living, the "More From Life" newsletter, surveys and general information.

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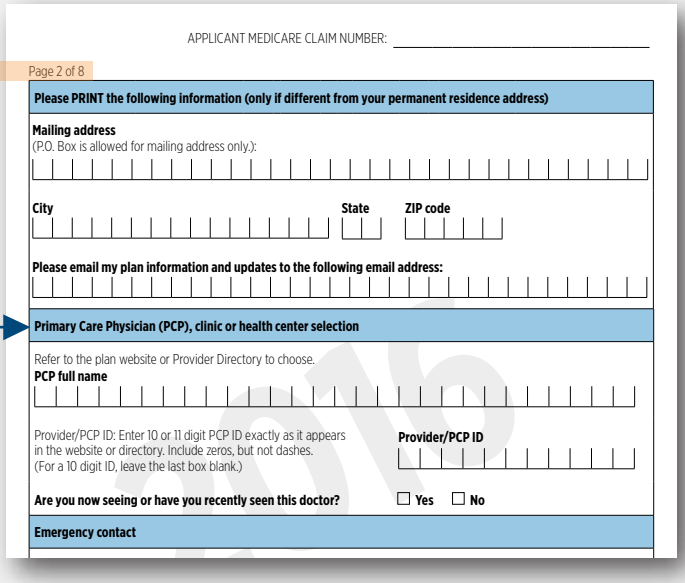
"Primary Care Physician selection"

It's vital that you include the PCP's full name and ID number which can be found in our Provider Directory. Call HAAL to verify the Provider is in network and accepting new patients. Do the same for the chosen Podiatrist.

- Answer the question that asks if the Applicant has seen these selected physicians before.



APPLICANT MEDICARE CLAIM NUMBER: _____

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Please PRINT the following information (only if different from your permanent residence address)

Mailing address
(P.O. Box is allowed for mailing address only.):

City State ZIP code

Please email my plan information and updates to the following email address:

Primary Care Physician (PCP), clinic or health center selection

Refer to the plan website or Provider Directory to choose.
PCP full name

Provider/PCP ID: Enter 10 or 11 digit PCP ID exactly as it appears in the website or directory. Include zeros, but not dashes. (For a 10 digit ID, leave the last box blank.)

Provider/PCP ID

Are you now seeing or have you recently seen this doctor? ☐ Yes ☐ No

Emergency contact

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Completing the Application *(continued)*

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"Please select a premium payment option"

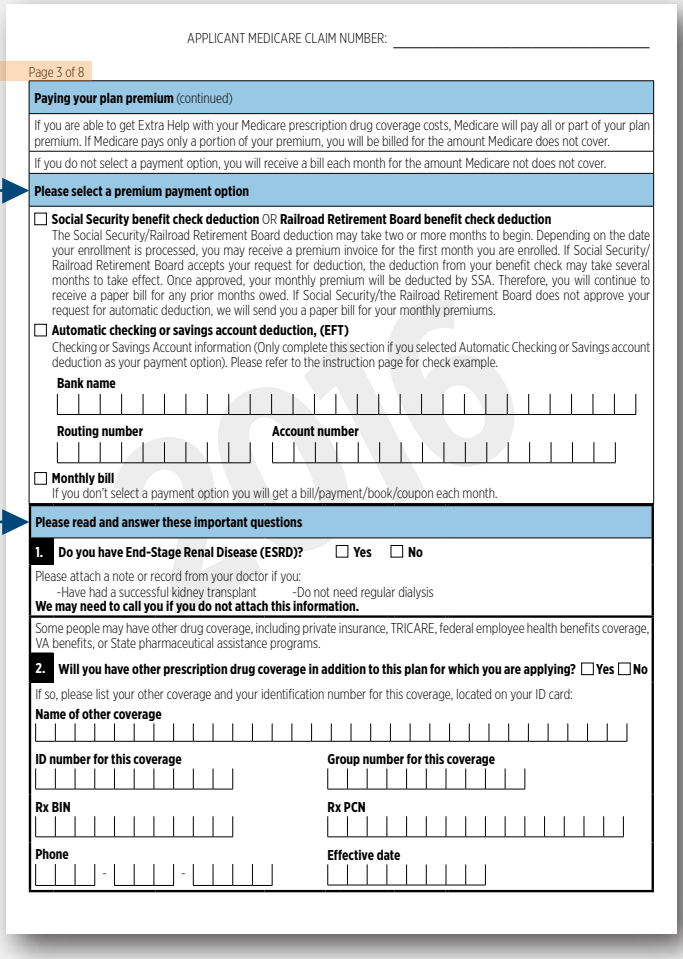
Mark method of premium payment. (The Encore Plan may be paid by check or Electronic Funds Transfer only.)

- Social Security benefit check deduction
  If the Applicant requests automatic deduction from their Social Security or Railroad Retirement benefit check, advise that it could take several months for this process to take effect. Their first deduction may include premiums for the previous several months. A paper bill will be sent if the request for automatic deduction is denied.
- Automatic checking or savings account deduction (EFT)
  Complete this section ONLY if this option is chosen. Fill the numbers out carefully and double-check them.
- Monthly bill
  If this box is selected, or if no other payment option is checked, the Applicant will get billed monthly.

"Please read and answer these important questions"

Answer every question in this section.

- If the ESRD question (**#1**) is answered "Yes," be certain to attach the additional information requested.
- If the Applicant has other additional Prescription Drug Coverage (**#2**), answer "Yes" and compare the information they entered with their ID card.
- If the "other medical health coverage" question (**#3**) is answered "Yes," check the Applicant's ID card to make sure that the carrier information entered is accurate and answer whether the coverage includes prescription drugs (**#4**).
- Be sure to enter answers to questions **#5**, **#6**, and **#7**



APPLICANT MEDICARE CLAIM NUMBER: _____

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Paying your plan premium (continued)

If you are able to get 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 your premium, you will be billed for the amount Medicare does not cover.

If you do not select a payment option, you will receive a bill each month for the amount Medicare not does not cover.

Please select a premium payment option

☐ **Social Security benefit check deduction** OR **Railroad Retirement Board benefit check deduction**
The Social Security/Railroad Retirement Board deduction may take two or more months to begin. Depending on the date your enrollment is processed, you may receive a premium invoice for the first month you are enrolled. If Social Security/ Railroad Retirement Board accepts your request for deduction, the deduction from your benefit check may take several months to take effect. Once approved, your monthly premium will be deducted by SSA. Therefore, you will continue to receive a paper bill for any prior months owed. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

☐ **Automatic checking or savings account deduction, (EFT)**
Checking or Savings Account information (Only complete this section if you selected Automatic Checking or Savings account deduction as your payment option). Please refer to the instruction page for check example.

Bank name

Routing number **Account number**

☐ **Monthly bill**
If you don't select a payment option you will get a bill/payment/book/coupon each month.

Please read and answer these important questions

1. **Do you have End-Stage Renal Disease (ESRD)?** ☐ **Yes** ☐ **No**

Please attach a note or record from your doctor if you:
-Have had a successful kidney transplant -Do not need regular dialysis
We may need to call you if you do not attach this information.

Some people may have other drug coverage, including private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

2. **Will you have other prescription drug coverage in addition to this plan for which you are applying?** ☐ **Yes** ☐ **No**

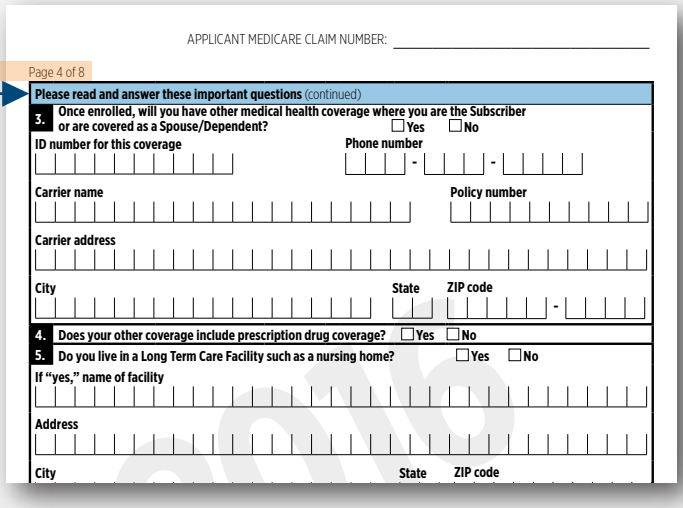
If so, please list your other coverage and your identification number for this coverage, located on your ID card:

Name of other coverage

ID number for this coverage **Group number for this coverage**

Rx BIN **Rx PCN**

Phone **Effective date**



APPLICANT MEDICARE CLAIM NUMBER: _____

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Please read and answer these important questions (continued)

3. **Once enrolled, will you have other medical health coverage where you are the Subscriber or are covered as a Spouse/Dependent?** ☐ **Yes** ☐ **No**

ID number for this coverage **Phone number**

Carrier name **Policy number**

Carrier address

City **State** **ZIP code**

4. **Does your other coverage include prescription drug coverage?** ☐ **Yes** ☐ **No**

5. **Do you live in a Long Term Care Facility such as a nursing home?** ☐ **Yes** ☐ **No**

If "yes," name of facility

Address

City **State** **ZIP code**

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Completing the Application *(continued)*

"Other languages or formats"

If Applicant selects one of the listed formats, future communications will be in that format whenever available. If they require information in a different language or format, have them contact Cigna-HealthSpring Customer service.

"STOP. Please read this important information"

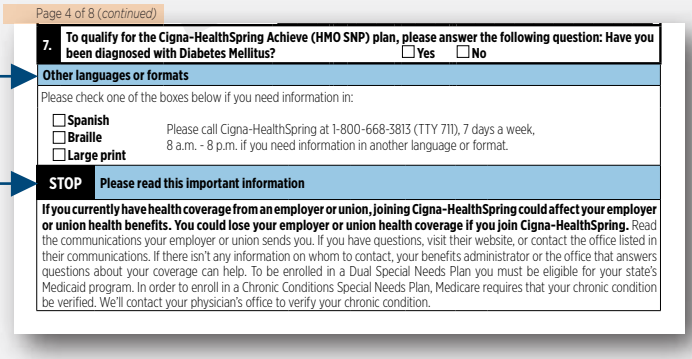
If Applicant is currently insured by an employer or union, advise them that their enrollment may be rejected at first. If so, Cigna-HealthSpring will advise how to complete the enrollment request.

Page 5

"Please read and sign below"

Have Applicant sign and date the application. (It's illegal for you to backdate, sign, or assist the Applicant in signing an enrollment form.)

- If signed by an Authorized Representative, they must also:
  - Provide the required information on the following page of the form to prevent delay or denial of the application.
  - Be prepared to produce documentation proving authority to sign.
- If assistance is needed, only these representatives are acceptable:
  - An appointed legal representative with a durable power of attorney, or
  - An individual authorized under state surrogate consent laws, providing they have authority to act for the beneficiary.
- In all cases, a representative's authority must pertain to health care decisions, not just financial or insurance decisions.



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7. **To qualify for the Cigna-HealthSpring Achieve (HMO SNP) plan, please answer the following question: Have you been diagnosed with Diabetes Mellitus?** ☐ Yes ☐ No

Other languages or formats

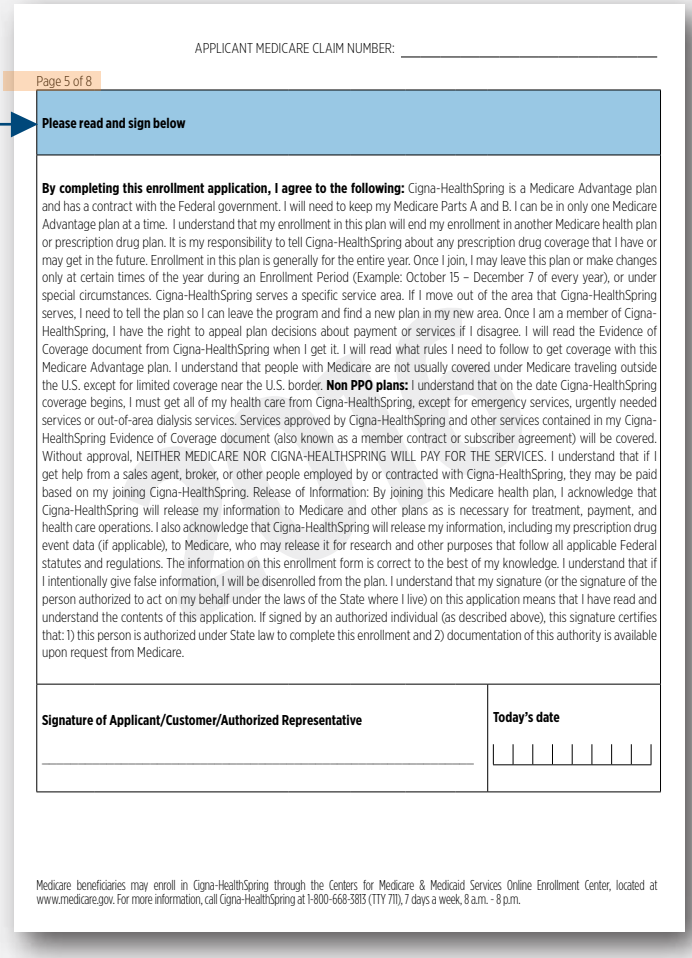
Please check one of the boxes below if you need information in:

☐ Spanish
☐ Braille
☐ Large print

Please call Cigna-HealthSpring at 1-800-668-3813 (TTY 711), 7 days a week, 8 a.m. - 8 p.m. if you need information in another language or format.

STOP **Please read this important information**

If you currently have health coverage from an employer or union, joining Cigna-HealthSpring could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Cigna-HealthSpring. 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. To be enrolled in a Dual Special Needs Plan you must be eligible for your state's Medicaid program. In order to enroll in a Chronic Conditions Special Needs Plan, Medicare requires that your chronic condition be verified. We'll contact your physician's office to verify your chronic condition.



APPLICANT MEDICARE CLAIM NUMBER: _____

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Please read and sign below

By completing this enrollment application, I agree to the following: Cigna-HealthSpring 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. I understand that my enrollment in this plan will end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to tell Cigna-HealthSpring about 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 join, I may leave this plan or make changes only at certain times of the year during an Enrollment Period (Example: October 15 – December 7 of every year), or under special circumstances. Cigna-HealthSpring serves a specific service area. If I move out of the area that Cigna-HealthSpring serves, I need to tell the plan so I can leave the program and find a new plan in my new area. Once I am a member of Cigna-HealthSpring, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Cigna-HealthSpring when I get it. I will read what rules I need to follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare are not usually covered under Medicare traveling outside the U.S. except for limited coverage near the U.S. border. **Non PPO plans:** I understand that on the date Cigna-HealthSpring coverage begins, I must get all of my health care from Cigna-HealthSpring, except for emergency services, urgently needed services or out-of-area dialysis services. Services approved by Cigna-HealthSpring and other services contained in my Cigna-HealthSpring Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without approval, NEITHER MEDICARE NOR CIGNA-HEALTHSPRING WILL PAY FOR THE SERVICES. I understand that if I get help from a sales agent, broker, or other people employed by or contracted with Cigna-HealthSpring, they may be paid based on my joining Cigna-HealthSpring. Release of Information: By joining this Medicare health plan, I acknowledge that Cigna-HealthSpring will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Cigna-HealthSpring will release my information, including my prescription drug event data (if applicable), to Medicare, who may release it for research and other purposes that 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 give false information, 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 of Applicant/Customer/Authorized Representative	**Today's date**
_____	

Medicare beneficiaries may enroll in Cigna-HealthSpring through the Centers for Medicare & Medicaid Services Online Enrollment Center, located at www.medicare.gov. For more information, call Cigna-HealthSpring at 1-800-668-3813 (TTY 711), 7 days a week, 8 a.m. - 8 p.m.

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Completing the Application
(continued)

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"Note to agents"
This entire page is important because your application could be denied if it's not filled in completely.

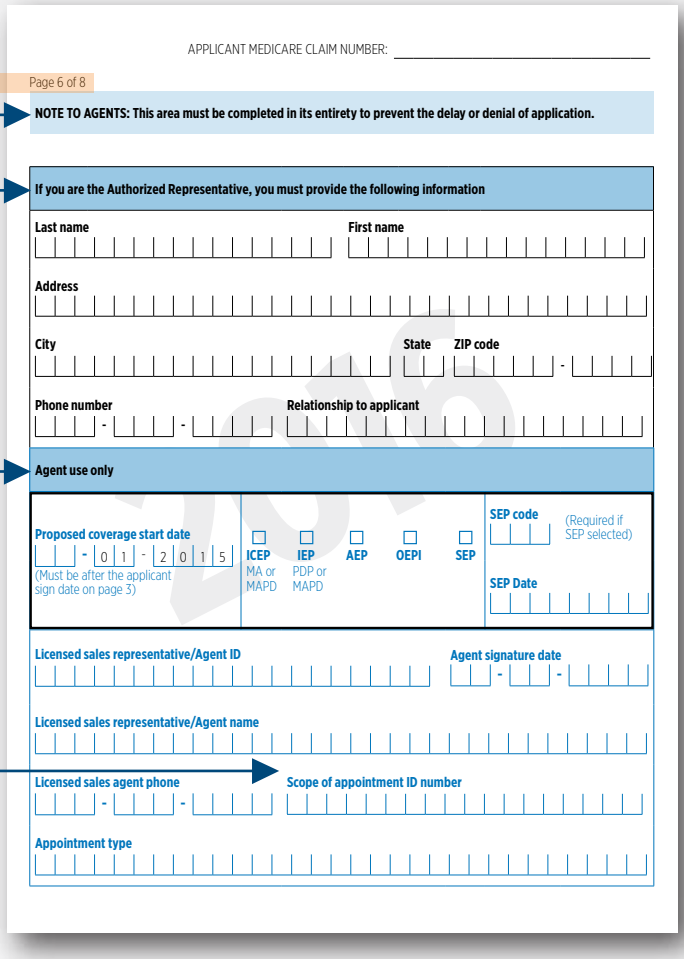
"If you are the Authorized Representative"
If the beneficiary's representative signed the application, have them supply the requested information here.

"Agent use only"
This information is used to ensure you get credited for each application.

- Enter the **Proposed coverage start date** which typically is the first day of the month after the Applicant's signature date. (Some exceptions apply.)
- Next, mark the election period box that applies. If you selected the **SEP** box, then include the **SEP code, date**, and any other necessary Special Election information.
- Clearly include your **writing number Agent ID** and your **signature date** (which will become the actual date of the application). Follow that with your name and phone number.
- **VERY IMPORTANT—Don't forget the SOA number!**

  For Telescope users
  Include the Applicant's Telescope ID in the **Scope of Appointment ID number** field on either your paper enrollment form or your electronic form.

  For paper Scope of Appointment users
  Create a unique ID using your Agent ID plus



APPLICANT MEDICARE CLAIM NUMBER: _____

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NOTE TO AGENTS: This area must be completed in its entirety to prevent the delay or denial of application.

If you are the Authorized Representative, you must provide the following information

Last name | First name

Address

City | State | ZIP code

Phone number | Relationship to applicant

Agent use only

Proposed coverage start date - 0 1 - 2 0 1 5
(Must be after the applicant sign date on page 3)

☐ ICEP MA or MAPD ☐ IEP PDP or MAPD ☐ AEP ☐ OEPI ☐ SEP

SEP code (Required if SEP selected)

SEP Date

Licensed sales representative/Agent ID | Agent signature date

Licensed sales representative/Agent name

Licensed sales agent phone | Scope of appointment ID number

Appointment type

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Completing the Application *(continued)*

date of appointment (mmddyy) plus military time. Example:
Your AGENT ID + 120715 + 1300

Next, enter this unique ID number in the **Scope of Appointment ID number** field on either your paper or electronic enrollment form. This ID should also be entered on your Paper Scope of Appointment in the **"To be Completed by Agent"** field.

- Lastly, include the **Appointment type**, for example, home visit, seminar, informal marketing event, telephonic, etc.

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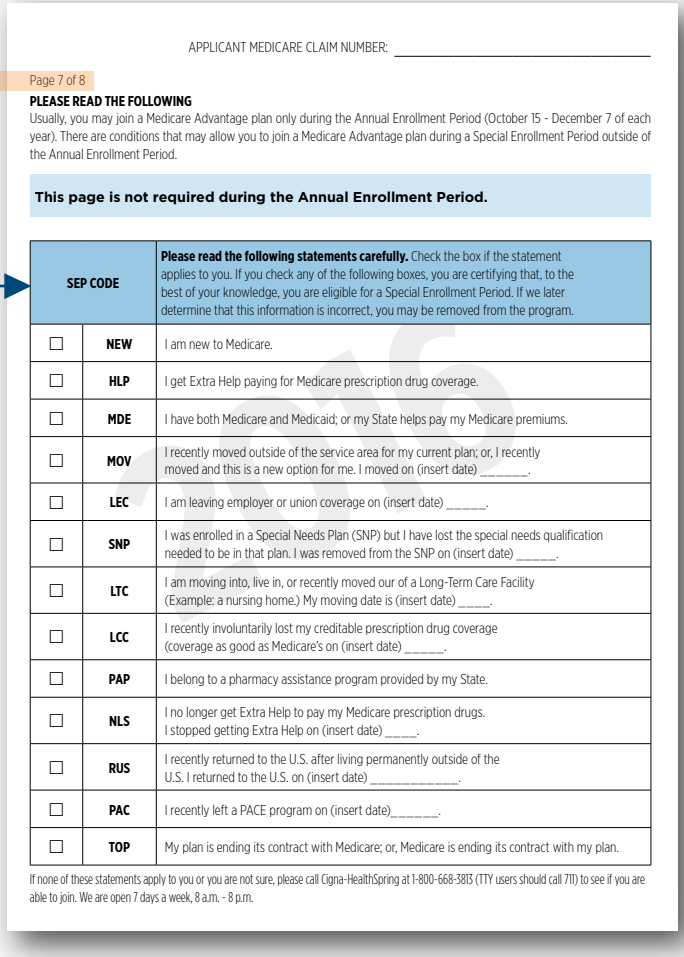
"SEP CODE"

If the applicant is eligible for a Special Enrollment Period outside of the Annual Enrollment Period, then they need to check all applicable boxes to certify that they are eligible for an SEP.



APPLICANT MEDICARE CLAIM NUMBER: _____

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PLEASE READ THE FOLLOWING

Usually, you may join a Medicare Advantage plan only during the Annual Enrollment Period (October 15 - December 7 of each year). There are conditions that may allow you to join a Medicare Advantage plan during a Special Enrollment Period outside of the Annual Enrollment Period.

This page is not required during the Annual Enrollment Period.

SEP CODE		**Please read the following statements carefully.** Check the box if the statement applies to you. If you check any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for a Special Enrollment Period. If we later determine that this information is incorrect, you may be removed from the program.
☐	**NEW**	I am new to Medicare.
☐	**HLP**	I get Extra Help paying for Medicare prescription drug coverage.
☐	**MDE**	I have both Medicare and Medicaid; or my State helps pay my Medicare premiums.
☐	**MOV**	I recently moved outside of the service area for my current plan; or, I recently moved and this is a new option for me. I moved on (insert date) _____.
☐	**LEC**	I am leaving employer or union coverage on (insert date) _____.
☐	**SNP**	I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification needed to be in that plan. I was removed from the SNP on (insert date) _____.
☐	**LTC**	I am moving into, live in, or recently moved our of a Long-Term Care Facility (Example: a nursing home.) My moving date is (insert date) _____.
☐	**LCC**	I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's on (insert date) _____.
☐	**PAP**	I belong to a pharmacy assistance program provided by my State.
☐	**NLS**	I no longer get Extra Help to pay my Medicare prescription drugs. I stopped getting Extra Help on (insert date) _____.
☐	**RUS**	I recently returned to the U.S. after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
☐	**PAC**	I recently left a PACE program on (insert date)_____.
☐	**TOP**	My plan is ending its contract with Medicare; or, Medicare is ending its contract with my plan.

If none of these statements apply to you or you are not sure, please call Cigna-HealthSpring at 1-800-668-3813 (TTY users should call 711) to see if you are able to join. We are open 7 days a week, 8 a.m. - 8 p.m.

Submit the Application

Applications must be submitted within 48 hours of your signature date using one of these two ways.

1 **Fax**

2 **e-Enrollment (If you are using a paper Scope of Appointment, remember to fax it.)**

In most cases, enrollment forms that we receive by the last working day of the current month will be effective on the first day of the next month.

Together, all the way.℠

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