Scope of Sales

Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of products(s) you want the agent to discuss.

_____ MEDICARE ADVANTAGE PLANS (PART C)

Medicare Health Maintenance Organization (HMO) Plan — A Medicare Advantage Plan provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. HMOs have network doctors and hospitals from which you must get your care and services.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: _____ Date: _____

If you are the representative, please sign above and print below:

Representative's Name: _____

Your Relationship to the Beneficiary:_____

To be completed by Agent:

Plan(s) the agent represented during this meeting: _____

Agent Name: _____ Agent Phone: _____

Beneficiary Name: _____ Beneficiary Phone: _____

Beneficiary Address: _____
(optional)

Initial Method of Contact: _____
(Indicate here if beneficiary was a walk-in.)

Date Appointment Completed: _____
*Scope of Appointment documentation is subject to CMS record retention requirements

Chronic Special Needs Plan (CSNP) Pre-Qualification Form

Chronic Special Needs Plan (CSNP) is a type of Medicare Advantage coordinated plan focused on individuals with special needs. HealthTeam Advantage offers a Chronic Special Needs Plan (CSNP) designed for people with certain chronic or disabling conditions.

You may be eligible to join our CSNP if you can answer YES to any of the questions below. HealthTeam Advantage will need to obtain verification of the chronic condition from your doctor within 30 days of enrollment. We are required to disenroll you from the special needs plan if we are unable to verify your chronic condition. ***It is very important, therefore, that you let your doctor know that we will require their verification and that you provide us with accurate contact information for your doctor at the bottom of this form.***

Has your doctor or other licensed health care professional diagnosed you with any of the following medical conditions? (Check all that apply):

Diabetes ____ YES ____ NO Congestive Heart Failure ____ YES ____ NO

Please Complete This Section If You Have Diabetes

Do you check your blood sugar at home?	____ YES	____ NO
Do you have high blood sugar?	____ YES	____ NO
Do you take medicine to control your blood sugar?	____ YES	____ NO

Please Complete This Section If You Have Congestive Heart Failure

Do you have fluid in your lungs?	____ YES	____ NO
Do you have swelling in your feet and legs almost every day because of too much fluid in your body?	____ YES	____ NO
Do you take medicine for the fluid in your lungs or to help your heart beat stronger?	____ YES	____ NO

Enrollment Request Form Instructions 2020 Plan Year

Please read before completing your enrollment request form.

You are eligible to join HealthTeam Advantage Diabetic & Heart Care Health Plan(s) HMO if:

- You are entitled to Medicare Part A and are enrolled in Part B;
- You do not have End Stage Renal Disease (ESRD);
- You live in Guilford County
- You are a United States Citizen or lawfully present in the United States
- You have diabetes and/or congestive heart failure

Please make sure you complete all necessary information on the enrollment request form and send all of the information to HealthTeam Advantage.

1. Complete all sections of the enrollment request form in full, including the plan you want to enroll in and your premium payment option. Missing or incomplete information may cause delay in the effective date of your coverage.
2. If you are using a mailing address that is different from your permanent residential address, please provide the name of the person and his/her address to which mail should be sent.
3. When completing the Medicare insurance information, please print your name exactly as it appears on your Medicare card.
4. Provide the name of your Primary Care Physician (PCP).
5. If you would prefer to receive information in a language other than English or in another format, please check the box indicated.
6. Your enrollment request form must be signed, dated, and received by HealthTeam Advantage by the last calendar day of the month in order for your coverage to be effective the first day of the following month.
7. Fax completed enrollment request form to 800-905-9131 or mail the completed enrollment request form to HealthTeam Advantage at:

HealthTeam Advantage
Attn: Enrollment Department
7800 McCloud Road, Suite 100
Greensboro, NC 27409

Other Important Information

- If you have questions about your enrollment request form, please call us at 1-877-905-9216 (TTY 711). A sales agent is available to help you seven days a week, 8 a.m. to 8 p.m. A sales agent will meet with you in-person to help you with your enrollment request form, if you prefer.
- HealthTeam Advantage determines when your enrollment request form is considered to be complete based on Medicare enrollment guidelines.
- Your enrollment with HealthTeam Advantage is subject to approval by the Centers for Medicare & Medicaid Services (CMS). If your enrollment is not accepted by CMS, we will notify you immediately.
- HealthTeam Advantage is not a Medicare Supplement. By enrolling in one of our plans, you will remain a part of the Medicare program. By selecting one of our plans, you will have Part C and Part D (MA-PD), which replaces Part A, Part B, and Part D (drug coverage).
- You may also enroll directly online or by phone. Go to HealthTeamAdvantage.com, or call 1-877-905-9216, TTY users call 711.

HealthTeam Advantage, a product of Care N' Care Insurance Company of North Carolina, Inc., is a Medicare Advantage organization with a Medicare contract. Enrollment in HealthTeam Advantage depends on contract renewal.

Individual Enrollment Request Form 2020 Plan Year

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Please contact HealthTeam Advantage if you need information in another acceptable language or format (Braille).

To Enroll in HealthTeam Advantage Diabetes & Heart Care Health Plans, Please Provide the Following Information:

Please check which plan you want to enroll in:

MA-PD Plans:

☐ HealthTeam Advantage Diabetes & Heart Care HMO $0 per month

Optional Supplemental Benefits Riders:

☐ HealthTeam Advantage Comprehensive Dental Rider $25 per month

Last Name:	First Name:	Middle Initial:	☐ Mr. ☐ Ms. ☐ Mrs.

Birth Date: (_ _ / _ _ / _ _ _ _) (MM/DD/YYYY)	Sex: ☐ M ☐ F	Home Phone Number: ( )	Alternate Phone Number: ( )

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

City:	County:	State:	ZIP Code:

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

City:	County:	State:	ZIP Code:

Emergency Contact:	Phone Number:	Relationship to You:

E-mail Address:

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

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.

Paying Your Plan Premium

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or "Electronic Funds Transfer (EFT)" each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay HealthTeam Advantage the Part D-IRMAA.

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or "Electronic Funds Transfer (EFT)" each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay HealthTeam Advantage the Part D-IRMAA.

People with limited incomes may qualify for *Extra Help* to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this *Extra Help*, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for *Extra Help* online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for *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 this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Get a Bill Monthly

☐ Electronic funds transfer (EFT) from your bank account each month.
Please enclose a VOIDED check or provide the following:

Account Holder Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Account type: ☐ Checking ☐ Savings

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

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Individual Enrollment Request Form 2020 Plan Year
continued

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Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD)? ☐ **Yes** ☐ **No**
If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.
Will you have other prescription drug coverage in addition to the HealthTeam Advantage Health Plan? ☐ **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

3. Are you a resident in 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): _____

4. Are you enrolled in your State Medicaid program? ☐ **Yes** ☐ **No**
If yes, please provide your Medicaid number: _____

5. Do you or your spouse work? ☐ **Yes** ☐ **No**

Please choose the name of a Primary Care Physician (PCP): _____

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: ☐ **Large Print** ☐ **Other**

Please contact HealthTeam Advantage at 1-888-965-1965, if you need information in another accessible format or language other than what is listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week (ET) from October 1 to March 31, and 8 a.m. to 8 p.m. Monday through Friday, from April 1 to September 30. TTY users should call 711.

STOP **Please Read This Important Information** STOP

If you currently have health coverage from an employer or union, joining HealthTeam Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join HealthTeam Advantage. 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.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:
HealthTeam Advantage 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, and I understand that my enrollment in this plan will automatically end my enrollment in another

Individual Enrollment Request Form 2020 Plan Year
continued

Medicare health plan or prescription drug plan. It is my responsibility to inform you of 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 enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

HealthTeam Advantage serves a specific service area. If I move out of the area that HealthTeam Advantage serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of HealthTeam Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from HealthTeam Advantage when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date HealthTeam Advantage coverage begins, I must get all of my health care from HealthTeam Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by HealthTeam Advantage and other services contained in my HealthTeam Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTHTEAM ADVANTAGE WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with HealthTeam Advantage, he/she may be paid based on my enrollment in HealthTeam Advantage.

Release of Information: By joining this Medicare health plan, I acknowledge that HealthTeam Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that HealthTeam Advantage will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which 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 provide false information on this form, 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:	**Today's Date:**

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

Name: _____ Relationship to Enrollee: _____

Address: _____ Phone Number: _____

Office Use Only:

Name of agent/broker (if assisted in enrollment): _____ NPN Number: _____

Plan ID#: _____ Effective Date of Coverage: _____

Date Application Received by Agent: _____

ICEP/IEP: _____ AEP: _____ OEP: _____ SEP (type): _____ Not Eligible _____

Chronic Condition Verification Form

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal law concerning the privacy of such information.

Release of Information

By joining HealthTeam Advantage PLAN (HTA), a Medicare Advantage Special Needs Plan for Chronic Conditions, I acknowledge that I have one or more of the following conditions:

☐ **Diabetes** ☐ **Chronic Heart Failure**

I authorize and direct _____ (Care Provider/Specialist) to confirm my chronic condition and disclose my medical records to HTA. This authorization shall be effective until I am no longer enrolled in HTA.

Application Use and Disclosure Authorization

APPLICANT, please complete if applicable.

Print Name of Applicant/Authorized Representative: _____

Medicare ID Number or Date of Birth: _____

Signature of Applicant/Authorized Representative: _____ Date: _____

If you are the authorized representative of the applicant, provide the following information:

Relationship to Applicant: _____ Telephone Number: _____

Provider Confirmation of Chronic Condition

CARE PROVIDER/SPECIALIST, please complete.

I, _____ (Care Provider/Specialist),

hereby certify that _____ (Applicant)

has the following health condition(s):

☐ **Diabetes** ☐ **Chronic Heart Failure**

Care Provider/Specialist Signature: _____ **Date:** _____

Fax this completed form to: 1-800-905-9131

Mail this form to: HealthTeam Advantage, 7800 McCloud Road Road, Suite 100, Greensboro, NC 27409
If you have any questions, please call: 1-877-905-9216, TTY 711, Monday—Friday, 8:00 a.m.—5:00 p.m.

Attestation of Eligibility for an Enrollment Period

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Individual Enrollment Request Form-2020

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.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ 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 (insert date) _____.
- ☐ I recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ☐ 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) _____.
- ☐ 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) _____.
- ☐ 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.
- ☐ 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) _____.
- ☐ I recently left a PACE program on (insert date) _____.

If none of these statements apply to you or you're not sure, please contact HealthTeam Advantage at 1-877-905-9216 (TTY 711) to see if you are eligible to enroll. We are open October 1-March 31, 8 a.m. to 8 p.m. ET, seven days a week or April 1-September 30, 8 a.m. to 8 p.m. ET, Monday through Friday.

Attestation of Eligibility for an Enrollment Period
continued

Individual Enrollment Request Form-2020

- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ☐ I am leaving employer or union coverage on (insert date) _____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ 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) _____.
- ☐ 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) _____.
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements apply to you or you're not sure, please contact HealthTeam Advantage at 1-877-905-9216 (TTY 711) to see if you are eligible to enroll. We are open October 1-March 31, 8 a.m. to 8 p.m. ET, seven days a week or April 1-September 30, 8 a.m. to 8 p.m. ET, Monday through Friday.

Application Checklist

BENEFICIARY: Please initial all applicable lines

___ 1. The agent reviewed the HealthTeam Advantage Diabetes & Heart Care (HMO) Summary of Benefits for all HealthTeam Advantage plans.

___ 2. I selected the HealthTeam Advantage plan that best fits my current Medicare needs.

___ 3. I understand that the plan I have chosen is NOT a Medicare supplement (Medigap) plan.

___ 4. The agent explained the assistance a HealthTeam Advantage Healthcare Concierge can provide.

___ 5. The agent reviewed prescription drug (Rx) needs and identified the tiers and related co-pays using the Drug List. The agent explained the Rx benchmark, 2020 coverage gap, new changes once the coverage gap is reached, step therapy (if required), late enrollment penalty, and prior authorization.

___ 6. The agent explained I must continue to pay the Medicare Part B premium.

___ 7. If I have current group coverage (active or retiree), the name of the carrier, policy number, ID number, customer service phone number(s), and effective date and term date are listed below:

Name of Other Carrier _____ Customer Service Phone # _____

Policy # _____ ID # _____ Effective Date __/__/__ Term Date __/__/__

___ 8. The agent gave me the following materials:

A. HealthTeam Advantage Diabetes & Heart Care Summary of Benefits C. Business Card

B. Multi-Language Insert

___ 9. If my recent move provided the opportunity to enroll in HealthTeam Advantage, my previous address was:

Street _____City_____ State _____ Zip Code _____

___ 10. The Primary Care Physician I have chosen is _____

**Network participation may change*

___ 11. The payment method I have selected is ☐ Monthly Invoice ☐ SSA Deduct ☐ ACH

OPTIONAL SUPPLEMENTAL COVERAGE:

___ 12. The agent reviewed the HealthTeam Advantage Comprehensive Dental Rider with me. If selected, the agent explained that this optional coverage requires an additional $25 monthly premium.

Beneficiary Signature:_____ Plan: _____

Agent Name/ID: _____ Date: _____

HealthTeam Advantage, a product of Care N' Care Insurance Company of North Carolina, Inc., is a Medicare Advantage organization with a Medicare contract. Enrollment in HealthTeam Advantage depends on contract renewal.

Receipt
Important Enrollment Info

Application Date: _____

Proposed Effective Date: _____

Medicare Id: _____

Plan Name: _____

Sales Agent Name: _____

Sales Agent Phone: _____

Sales Agent Id: _____

Thank You for Enrolling
in HealthTeam Advantage!

This receipt verifies that you completed an enrollment form with an agent who sells HealthTeam Advantage HMO Medicare Advantage health plans.

To speak with a sales agent, call 1-877-905-9216 (TTY 711), October 1-March 31, 8 a.m. to 8 p.m. ET seven days a week or April 1-September 30, 8 a.m. to 8 p.m. ET, Monday through Friday, or visit HealthTeam Advantage at HealthTeamAdvantage.com.

What's Next?

The following next steps will help you better understand what to expect on your way to becoming a HealthTeam Advantage HMO Member.

THE DAY YOU ENROLL…

- Receipt of completed enrollment form: The agent will provide a receipt that confirms you submitted an enrollment form. If you enroll online, you will receive a confirmation number and you will have the ability to print an electronic copy of your completed application for your files.

WITHIN 10 DAYS OF SUBMITTING ENROLLMENT FORM…

- Letter confirming receipt of your enrollment and enrollment approval from Medicare to the HealthTeam Advantage plan you selected.

WHEN YOU BECOME A HealthTeam Advantage MEMBER…

- HealthTeam Advantage Evidence of Coverage: This book is your detailed coverage of your plan.
- HealthTeam Advantage member identification cards: You will receive your HealthTeam Advantage HMO member identification card.
- Personal Healthcare Concierge at your service: If you would like assistance finding a provider, scheduling an appointment, have questions about your benefits, or need a replacement identification card, simply email your concierge at conciergehta@HealthTeamAdvantage.com, or call your Healthcare Concierge at 1-833-324-3242. Our hours of operation are:
    - October 1-March 31: 8 a.m. to 8 p.m. ET, seven days a week.
    - April 1-September 30: 8 a.m. to 8 p.m. ET, Monday through Friday.