

Thank you for your interest in applying for the GroupHealth Medicare Advantage plan.

If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date.

Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15th to December 7th 2011. This will give you a January 1st 2012 effective date for your new plan. Applications must be signed and dated on, or between October 15th and December 7th 2011. If they are signed prior to October 15th they will be returned to you with a new application. If they are received after December 7th, you will not be able to change plans until the next AEP for January 2013.

This application needs to be reviewed and signed by an Agent before it can be submitted to GroupHealth. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: dann@lowinsure.com
- Mail: CDA Insurance LLC
2160 W 11th Ave
Eugene, Oregon 97402

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

Group Health Cooperative Clear Care® HMO & HMO SNP election form

Clear Care HMO plans are Medicare Advantage plans

SECTION 1: Personal information

Name (as it appears on Medicare card)

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	First name	Middle initial	Last name
	Birth date		<input type="checkbox"/> Male <input type="checkbox"/> Female

Permanent residential address (do not use a P.O. box or a mail delivery service)

Street address			Length of time at this address
City	County	State	ZIP

Mailing address (if different than above)

Address			In care of
City	County	State	ZIP

Premium billing address (if different than above)—we will send your monthly bill here.

Address			In care of
City	County	State	ZIP

Contact information

Telephone (primary)	Telephone (secondary)	Group Health member number (if applicable)
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If we need additional information in order to complete the processing of this election form, may we use e-mail to communicate with you?

<input type="checkbox"/> Yes <input type="checkbox"/> No	E-mail address (optional)
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SECTION 2: How did you hear about Clear Care Medicare Advantage plans?

- | | | |
|--|---|--|
| <input type="checkbox"/> Referral | <input type="checkbox"/> Doctor/clinic (medical center) | <input type="checkbox"/> Seminar/presentation |
| ___ Spouse | <input type="checkbox"/> Broker/agent | <input type="checkbox"/> Group Health sales representative |
| ___ Family/friend/
neighbor | <input type="checkbox"/> My work/employer | <input type="checkbox"/> Group Health website ghc.org |
| <input type="checkbox"/> Medicare.com/
Medicare & You/CMS | <input type="checkbox"/> TV | <input type="checkbox"/> Newspaper |
| | <input type="checkbox"/> Radio | <input type="checkbox"/> Direct mail |

Please check the appropriate box:

- Former Group Health member New to Group Health Current Group Health member

SECTION 3: Medicare information

Please complete this section with the information on your red, white, and blue Medicare card, or please attach a copy of your Medicare card, your letter of verification from the Social Security Administration, or your letter of verification from the Railroad Retirement Board. You must have Medicare Parts A and B to join a Medicare Advantage plan.

Medicare Claim number _____

Medicare Part A (hospital) effective date _____

Medicare Part B (medical) effective date _____

Medicare	Health insurance
CENTERS FOR MEDICARE & MEDICAID SERVICES	
NAME OF BENEFICIARY JANE SMITH	
MEDICARE CLAIM NUMBER 123-45-6789-A	SEX FEMALE
IS ENTITLED TO HOSPITAL (PART A) MEDICAL (PART B)	EFFECTIVE DATE 11-1-98 11-1-98
SIGN HERE _____	

SECTION 4: Medical information

1. Do you currently have End-Stage Renal Disease (ESRD)—permanent kidney failure requiring regular kidney dialysis or a transplant to stay alive? Yes No

If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant.**

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 your Clear Care plan? Yes No

If yes, name of other plan _____

ID # for other plan _____ Group # for other plan _____

Effective date of other plan _____

Continued next page

SECTION 4 continued: Medical information

3. Do you live in a long-term care facility, such as a nursing home? Yes No

If yes, name of facility _____

Address of facility _____

Phone number of facility _____ Date admitted _____

4. Are you enrolled in a state Medicaid program? Yes No

If yes, Medicaid number: _____

5. If you are enrolling in the Clear Care Sound plan, please answer this question:
Has your doctor told you that you have diabetes? Yes No

SECTION 5: Complete for individual Medicare Advantage coverage

1. Select only one Clear Care HMO Plan

Group Health Cooperative Clear Care®
Vital HMO: **\$19** per month

Group Health Cooperative Clear Care®
Essential HMO: **\$118** per month

Group Health Cooperative Clear Care®
Optimal HMO: **\$212** per month

Group Health Cooperative Clear Care®
Basic HMO: **\$35** per month

*(Clear Care Basic does not include
prescription drug coverage)*

Group Health Cooperative Clear Care®
Sound HMO SNP: **\$115** per month

Important: The Clear Care Sound HMO SNP plan is only available to residents of King and Pierce counties who have Medicare Parts A and B and who have been diagnosed with diabetes. **If enrolling in the Clear Care Sound plan, please complete the enclosed Consent Form and provide a letter from your current physician confirming your diagnosis of diabetes.** If you do not have diabetes, your application will be denied.

2. If you want the optional dental plan for 2012, be sure to check the box below.

Dental plan: **\$49** per month (in addition to monthly premium)

SECTION 6: Complete if your employer offers a Medicare employer group plan

1. Are you enrolling through an employer group or employer retiree plan? Yes No
If not, please go to Section 7.

Employer or union group name _____ Group number _____

If you currently have health coverage from an employer or union, joining one of the Clear Care plans could effect your employer or union health benefits. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

SECTION 7: By completing this election form, you agree to the following:

A Coordinated Care plan with a Medicare Advantage contract. You will need to keep your Medicare Parts A and B coverage. You must continue to pay your Medicare Part B premium. Limitations, copayments, and restrictions may apply. You can only be in one Medicare Advantage plan at a time, and understand that your enrollment in this plan will automatically end your enrollment in another Medicare health plan or prescription drug (MAPD) plan. It is your responsibility to inform Group Health of any prescription drug coverage that you have or may get in the future. If you do not have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future. You must use network pharmacies to access prescription drug benefits, except in non-routine circumstances, and quantity limitations and restrictions may apply. Enrollment in this plan is generally for the entire year. Once you enroll, you may leave this plan ("disenroll") or make changes only at certain times of the year when an enrollment period is available, or under certain special circumstances. Members may enroll in the plan only during specific times of the year. The enrollment period is October 15–December 7.*

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for Extra Help, call:

- **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**, 24 hours a day/7 days a week;
- The Social Security Office at **1-800-772-1213** between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778**; or
- Your state Medicaid office

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.

Clear Care plans serve a specific service area. If you move out of the area that the Clear Care plans serve, you need to notify the plan so you can disenroll and find a new plan in your new area. Once you are a Clear Care plan member, you have the right to appeal plan decisions about payment or services if you disagree. Read your plan's Evidence of Coverage from Group Health when you receive it to learn which rules you must follow in order to get coverage with this Medicare Advantage plan. People with Medicare are not usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

Beginning on the date your Clear Care coverage begins, you must use plan providers except in emergency or urgent care situations or for out-of-area renal dialysis. Those services authorized by Group Health and other services contained in your Clear Care plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. If you obtain routine care from out-of-network providers without authorization, **neither Medicare nor Group Health will pay for the services.**

If you are receiving assistance from a sales agent, broker, or other individual employed by or contracted with Group Health, he/she may be paid based on your enrollment in a Clear Care plan.

Please initial here: _____

* The Sound plan is open for enrollment throughout the year.

SECTION 8: Paying your plan premium

You can pay your monthly plan premium including any late enrollment penalty (if you are on a Medicare Advantage plan that includes prescription drug coverage) that you currently have or owe by mail, by “Electronic Funds Transfer (EFT),” or by credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month if you receive SSA or RRB income. If you don’t select a payment option, you will get a bill for your premium each month.

Please select a premium payment option:

- | | |
|--|---|
| <input type="checkbox"/> Receive a monthly bill from Group Health. | <input type="checkbox"/> Group Health Automated Payment Plan (electronic funds transfer). |
| <input type="checkbox"/> Automatic deduction from your monthly Social Security benefit check.* | |
| <input type="checkbox"/> Automatic deduction from your monthly Railroad Retirement Board benefit check.* | |

* This automatic deduction may take two or more months to begin. If there is a delay, we will bill you monthly until the automatic deduction begins. This payment option is limited to premiums that do not exceed \$200 per month.

If you choose this option, your monthly premium for the individual Clear Care plan you selected will be deducted from your bank account. Payment will be deducted between the 7th and 10th day of each month for the current month’s premium. To enroll in the Automated Payment Plan, complete the Group Health Transfer of Funds form.

SECTION 9: Questions

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information, contact the plan. Group Health’s CMS contract is reviewed annually; therefore, our contract with CMS may not renew, resulting in the termination of coverage with Group Health.

To obtain information or to ask questions regarding this election form, please call Customer Service staff Monday through Friday, from 8 a.m. to 8 p.m. at **1-888-901-4600**. From October 15, 2011 to February 14, 2012, we will offer extended hours, 8 a.m. to 8 p.m.,

seven days a week. Or call TTY WA Relay (for the hearing- or speech-impaired) at **1-800-833-6388** or **711**.

This information is available for free in other languages. Please contact our Customer Service number at **1-888-901-4600** for additional information. (TTY users should call **1-800-833-6388** or **711**.) Hours are Monday–Friday from 8 a.m. to 8 p.m. From October 15 to February 14, call daily from 8 a.m. to 8 p.m. Customer Service also has free language interpreter services available for non-English speakers.

Continued on back page

SECTION 10: Release of information

By joining this Medicare Advantage health plan, I acknowledge that Group Health Cooperative will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Group Health Cooperative will release my information including my prescription drug event data (if I join a Medicare Advantage plan with prescription drug benefits) 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 by Group Health Cooperative or by Medicare.

Your signature _____ Date _____

If you are the authorized representative, you must sign above and provide the following information. Proof of your authority must be presented to Group Health or to Medicare upon request.

Name _____ Phone _____

Relationship to applicant _____

Address _____

To be completed by appointed brokers or agents

Broker or agent name Dann Loewenthal

Group Health agent ID number B6082

Company/house name (if applicable) _____

Group Health house ID number H1769

Phone number 800.884.2343

Receipt date _____

GHC Date-Stamp:

Name of staff member (if assisted in enrollment)

Effective date of coverage _____ / _____ / _____
(MM/DD/YYYY)

ICEP/IEP AEP Not eligible

SEP (reason if SEP) _____