Empire MediBlue (HMO)
Individual Enrollment Request Form — 2012

Empire BlueCross

Be sure to complete the entire enrollment form. Then, **mail** the completed form to **P.O. Box 659403, San Antonio, TX 78265-9714** ***or*** **fax** the completed form to **1-800-833-8554**. You can also enroll online at **www.empireblue.com/medicare**. ***Note****:* Your agent/broker may provide different instructions.
Please contact Empire BlueCross if you need information in another language or format (Large Print or Braille).

To enroll in Empire MediBlue (HMO), please provide the following information.

Please check which plan you want to enroll in:

☐ **Empire MediBlue Plus (HMO)**
$61.00 per month

Last name	**First name**	**Middle initial**	☐ **Mr.** ☐ **Mrs.** ☐ **Ms.**
Birth date (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	**Sex** ☐ M ☐ F	**Home phone number** ( )	**Alternate phone number** ( )

Permanent residence street address (P.O. Box is not allowed.)

City	State	ZIP code	County

Mailing address (only if different from your permanent residence address)

Street address City State ZIP code

Email address

Please provide your Medicare insurance information.

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

- Please fill in these blanks so they match your Medicare card.

- OR -

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

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

SAMPLE ONLY

Name _____

Medicare Claim Number Sex ___

__ __ __ - __ __ - __ __ __ __

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Applicant Complete: Name _____ and Medicare ID number_____

Y0071_12_12311_R_032 CMS Approved 08/12/2011

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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 or electronic funds transfer (EFT) each month. You also can 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 Empire BlueCross 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 also can 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 choose one of the options below: (If no option is chosen, you will receive a monthly bill for the amount due.)

☐ **Monthly Bill**: Send me a bill each month.

☐ **Automatic Bank Account Deduction**: Electronic funds transfer (EFT) from my bank account each month. (Depending on when you apply, more than one month's amount might be deducted for your ***first*** payment.) Please complete steps 1, 2 and 3 below:

1) Account type: ☐ **Checking**: Must enclose a VOIDED check. ☐ **Savings**: Must enclose letter from financial institution with account information.

2) Please complete the following information for your account:
Account holder name _____ Account number _____

Bank routing number _____ Bank name _____
(This is the first 9 digits printed on the lower left corner of your check.)

3) ☐ I authorize the bank above to allow this monthly deduction of the amount from the account above.

☐ **Automatic Social Security or Railroad Retirement Board (RRB) Deduction**: Deduct the amount from my Social Security or Railroad Retirement Board (RRB) benefit check each month. (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 date 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.)

Applicant Complete: Name _____ and Medicare ID number_____

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 anymore, 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 your Empire MediBlue (HMO)? ☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage	ID number for this coverage	Group number 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 (number and street) and phone number of institution _____
_____

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).

PCP name _____

PCP address _____

PCP ID number (see directory.) _____

New physician for you? ☐ Yes ☐ No

Please check one of the boxes below if you would prefer that we send you information in another format:

_____ Large Print _____ Braille

Please contact an Empire BlueCross Customer Service agent at **1-800-499-9554** if you need information in another language or format than what is listed above. Our office hours are 8 a.m. to 8 p.m., 7 days a week. TTY users should call **1-800-241-6894**.

Applicant Complete: Name _____ and Medicare ID number_____

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STOP

Please read this important information.

If you currently have health coverage from an employer or union, joining Empire MediBlue (HMO) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Empire MediBlue (HMO). 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.

Typically, you may enroll in a Medicare Advantage (MA) plan only during the Annual Enrollment Period (AEP) between October 15 and December 7 of each year. Additionally, there are exceptions — i.e., Initial Enrollment Period (ICEP) and Special Enrollment Periods (SEPs) — that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements carefully and check all of the boxes where there is a statement that 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. **NOTE: You must select at least one of the options below**.

- ☐ I am enrolling during the Annual Open Enrollment Period from October 15 to December 7. (AEP)
- ☐ I am new to Medicare. (ICEP)
- ☐ 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) _____. (SEP)
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums. (SEP)
- ☐ I get Extra Help paying for Medicare prescription drug coverage. (SEP)
- ☐ I no longer qualify for Extra Help paying for my Medicare prescription drugs. I stopped receiving Extra Help on (insert date) _____. (SEP)
- ☐ 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) _____. (SEP)
- ☐ I recently left a Program of All-inclusive Care for the Elderly (PACE®) program on (insert date) _____. (SEP)
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____. (SEP)
- ☐ I am leaving employer or union coverage on (insert date) _____. (SEP)
- ☐ I belong to a pharmacy assistance program provided by my state. (SEP)
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____. (SEP)
- ☐ My plan is ending its contract with Medicare or Medicare is ending its contract with my plan. (SEP)
- ☐ None of these statements applies to me.*

*Please contact an Empire BlueCross licensed insurance agent at **1-800-809-7328** (TTY users should call **1-800-241-6894**) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., 7 days a week.

Applicant Complete: Name _____ and Medicare ID number_____

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Please read and sign below.

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

Empire MediBlue (HMO) 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 automatically will end my enrollment in another 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. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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 (for example, October 15 – December 7 of every year), or under certain special circumstances.

Empire MediBlue (HMO) serves a specific service area. If I move out of the area that Empire BlueCross 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 Empire MediBlue (HMO), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Empire BlueCross 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 usually aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Empire MediBlue (HMO) coverage begins, I must get all of my health care from Empire BlueCross, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Empire BlueCross provides refunds for all covered benefits, even if I get services out of network. Services authorized by Empire BlueCross and other services contained in my Empire MediBlue (HMO) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR EMPIRE BLUECROSS 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 Empire BlueCross, he/she may be paid based on my enrollment in Empire MediBlue (HMO).

Applicant Complete: Name _____ and Medicare ID number_____

Release of Information: By joining this Medicare health plan, I acknowledge that Empire BlueCross will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Empire BlueCross 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**
Desired plan effective date:	
If you are the authorized representative, you must sign above and provide the following information: **Name** _____ **Address** _____ _____ **Phone number** (____) _____- _____ Relationship to enrollee _____	

Applicant Complete: Name _____ and Medicare ID number_____

Applicant: Please do not complete the following sections. *For office and agent/broker use only*.

***Internal agents or external agents/brokers, please complete*:** Coverage effective date ____/____/_____

☐ ICEP/IEP ☐ AEP ☐ SEP (type): _____ ☐ Not eligible

PLAN ID #: _____ NIPR #: _____

1. Was this an individual face-to-face appointment? ☐ Yes ☐ No (Do not proceed.)
2. If this was an individual face-to-face appointment, how was a scope of appointment (SOA) collected?
   ☐ Paper
   ☐ Recorded call (voice vault confirmation number _____)
3. Was the SOA signed on the same day as the appointment? ☐ Yes ☐ No (do not proceed)
4. If yes, please indicate the best reason below:

☐ Appointment was requested at the end of the month for the following month enrollment

☐ Customer walk-in

☐ Request for individual appointment immediately following a seminar sales event

☐ Next day appointment

☐ Other _____

***Direct sales reps only*:** Complete if you assisted in enrollment.

Print name _____

Tax identification number (10 digits) or agent code (variable) |___|___|___|___|___|___|___|___|___|___|

Signature _____ Application received date _____/_____/_____

***External agents/brokers only*:** application received ___/___/___

I helped the applicant fill out this application ☐ Yes ☐ No

**REQUIRED/MANDATORY: Please fill in BOTH required fields - 'Writing Agent' and 'Agency' with your assigned Code, Tax ID, or Encryption based on your appointed brand, state AND product.*

Writing Agent TIN/Agent Code

|___|___|___|___|___|___|___|___|___|___|

Agency TIN/Agency Code (NOTE: If you are directly appointed, populate your writing information again.)

|___|___|___|___|___|___|___|___|___|___|

External agent/broker's

Signature _____

***Please complete all lines below*.**

Agent/broker's printed name

_____

Agency name _____

_____

Street address

_____

City State ZIP code

Phone number (____) _____- _____

Fax number (____) _____- _____

Email address

_____

This plan is an HMO plan with a Medicare contract. Services provided by Empire HealthChoice HMO, Inc., licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

Applicant Complete: Name _____ and Medicare ID number_____

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