BlueCross BlueShield of North Carolina

Plans are offered by PARTNERS National Health Plans of North Carolina Inc., and administered by BCBSNC, its parent company.

PO Box 17168
Winston Salem, NC 27116-7168

Enrollment Form 2008

BlueMedicare HMO℠
BlueMedicare PPO℠

MedicareRx
Prescription Drug Coverage

For Plan Office Use Only

Member # J _____
Effective Date _____
Group # _____
☐ AEP ☐ ICEP ☐ Not Eligible
☐ OEP ☐ SEP (type) _____

A. Personal Information *(Please PRINT your name **exactly** as it appears on your Medicare card.)*

First Name *Middle Initial* *Last Name* *Jr., Sr.*

Birth Date M M / D D / Y Y Y Y

Gender *(Choose One)* ☐ Male ☐ Female

Phone - -

Residence Street Address *(No PO Boxes)*

City State Zip

County Social Security No. *(Optional)* - -

Mailing Address *(If different from residence, PO Box allowed)*

City State Zip

Emergency Contact Name *(Optional)*

Relationship to you Phone - -

B. Medicare Information

Please fill in your claim number and effective dates ***exactly*** as they appear on your Medicare Card, or attach a copy of your Medicare Card, or your confirmation letter of Medicare eligibility.

MEDICARE HEALTH INSURANCE

Medicare Claim Number

Is Entitled To:	Effective Date
Hospital Part A:	M M / D D / Y Y
Medical Part B:	M M / D D / Y Y

You **must** have Medicare Parts A and B to enroll.

C. Select your Plan and Benefit Package

☐ Blue Medicare HMO
- ☐ Enhanced ..... $59.00 per month
- ☐ Medical Only ..... $0.00 per month
- ☐ Standard..... $22.00 per month

☐ Blue Medicare PPO
- ☐ Enhanced Plus ..... $101.60 per month
- ☐ Enhanced ..... $67.40 per month

D. Select your Primary Care Provider (PCP)

Name of Primary Care Provider (Required):

PCP Code PCP Phone - -

☐ Current Patient ☐ New Patient

E. Select your Payment Option

You can pay your monthly plan premium by bank draft or by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security Check each month. 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 does not cover. Generally you must stay with the option you choose for the rest of the year.

☐ Bank Draft deduction from my bank account each month. (Complete and attach Bank Draft Form.)

☐ Send me a bill each month. (Additional payment options are listed on the bill that you will receive each month.)

☐ Automatically deduct the premium from my monthly SSA benefit check. (The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA benefit check will include ALL premiums due from your enrollment effective date up to the point withholding begins.)

F. Please read and answer these important questions

☐ Yes ☐ No 1. Do you have End Stage Renal Disease (ESRD)? **If "yes"** but you do not need regular dialysis anymore, 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.

☐ Yes ☐ No 2. Some individuals may have other drug coverage, including other private health insurance (includes retiree benefits), TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Blue Medicare HMO or Blue Medicare PPO that will continue after enrollment? **If "yes,"** please list your other drug coverage and your identification (ID) number(s) for this coverage:

Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Group # ☐☐☐☐☐☐

Phone ☐☐☐-☐☐☐-☐☐☐☐ ID# ☐☐☐☐☐☐☐☐☐☐

☐ Yes ☐ No 3. Are you a resident in a long-term care facility, such as a nursing home?

If "yes" please provide the following information:

Name of Institution ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Address of Institution ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State ☐☐ Zip ☐☐☐☐☐

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

If "yes," please provide your Medicaid number ☐☐☐☐☐☐☐☐☐☐

☐ Yes ☐ No 5. Do you or your spouse work? **If "yes,"** you will be sent a survey to complete and mail back to us.

G. Please Read this Important Information regarding Employer Health Benefits

STOP

If you currently have health coverage from an employer or union, joining Blue Medicare HMO or Blue Medicare PPO could affect 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.

H. Eligibility to Enroll (Please check one)

- ☐ I am enrolling during the Annual Enrollment Period (AEP) Nov. 15 through Dec. 31
- ☐ I am enrolling during the Open Enrollment Period (OEP) Jan. 1 through Mar. 31, but understand that I cannot change my prescription drug coverage
- ☐ I am new to Medicare or just turning 65 and am enrolling during my Initial Coverage Election Period (ICEP)
- ☐ I am enrolling during a Special Enrollment Period (SEP). Select reason:
  - ☐ I recently moved into the Service Area on: Date M M / D D / Y Y Y Y
    From: County _____ State _____
  - ☐ I am losing coverage or dropping coverage I had from an employer as of: M M / D D / Y Y Y Y
    Employer Name: _____ Phone _____-_____-_____
  - ☐ I receive extra help paying for Medicare prescription drug coverage
  - ☐ I am no longer eligible to receive extra help paying for my Medicare prescription drugs
  - ☐ I recently involuntarily lost my Creditable prescription drug coverage on:
    Date M M / D D / Y Y Y Y Plan Name: _____
  - ☐ I recently moved into or out of a Long Term Care Facility
  - ☐ I recently "left" a PACE program (Program of All-Inclusive Care for the Elderly)
  - ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums
  - ☐ Other _____

I. Applicant Agreement

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of North Carolina) on this application means that I have read and understand the contents of this application and the Statements of Understanding and Release of Information on the back of this page.

Your Signature _____ Today's Date: M M / D D / Y Y Y Y

If signed by an authorized individual, 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 Blue Medicare HMO or Blue Medicare PPO or by Medicare. Please **attach** documentation with this application.

Name _____ Signature _____

Address _____

City _____ State _____ Zip _____

Phone _____-_____-_____ Relationship to beneficiary _____

I have assisted the applicant in filling out the application.

Print Name _____ Signature _____

LICENSED AGENT USE ONLY

Agent's Signature _____ Date App Received _____

Print Agent's Name _____ Agent Number _____

Street Address _____ Telephone Number _____

City _____ State _____ Zip _____

Statement of Understanding

1. I understand that I am enrolling in a Medicare Advantage plan and I will need to keep my Parts A and B insurance by continuing to pay the Part A and Part B premiums, if applicable. I can only be in one Medicare Advantage plan at a time.
2. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
3. I understand that if I do not have Medicare prescription drug coverage, or Creditable prescription drug coverage (as good as Medicare's), I may have to pay a Late Enrollment Penalty (LEP) if I enroll in Medicare prescription drug coverage in the future.
4. I understand that enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Blue Medicare HMO or Blue Medicare PPO or by calling 1-800-Medicare, TTY users should call 1-877-486-2048, 24 hours a day/7days a week.
5. I understand that Blue Medicare HMO and Blue Medicare PPO serve a specific service area. If I move out of the area that Blue Medicare HMO and Blue Medicare PPO serves, I need to notify the plan so I can disenroll and find a new plan in my new area.
6. I understand that once I am a member of Blue Medicare HMO or Blue Medicare PPO, I have the right to appeal plan decisions about payment or services if I disagree.
7. I will read the Evidence of Coverage from Blue Medicare HMO or Blue Medicare PPO when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.
8. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country. Emergency care is covered world-wide.
9. Blue Medicare HMO members only. I understand that beginning on the date Blue Medicare HMO coverage begins, I must get all of my health care from Blue Medicare HMO, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Blue Medicare HMO and other services contained in my Blue Medicare HMO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR BLUE MEDICARE HMO WILL PAY FOR THE SERVICES.
10. I understand that the person discussing plan options with me is either employed by or contracted with Blue Medicare HMO or Blue Medicare PPO. The person may be compensated based on my enrollment in a plan.

Release of Information

1. By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.
2. I also acknowledge that Blue Medicare HMO or Blue Medicare PPO 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.
3. 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.