Prescription Blue℠ PDP

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

HOW TO ENROLL IN PRESCRIPTION BLUE PDP

We're here to help.

- Need help completing your application?
- Want more information?
- Have questions?
- Interested in finding an independent agent licensed to sell the Blues?

Please call us at **1-888-563-3307**. Our hours are 8 a.m. to 9 p.m., Monday through Friday with weekend hours Oct. 1 through Feb. 14. **TTY users should call 711.**

Ready to enroll in Prescription Blue PDP?

Enroll online by visiting: www.bcbsm.com/medicare/pdp.shtml or The Centers for Medicare and Medicaid Services Online Enrollment Center at www.medicare.gov/find-a-plan.

OR

Enroll using this form. Here are some helpful hints:

- Use a black or blue ink pen.
- Complete a separate form for each person enrolling. If you need another copy, make a photocopy or call us.
- Print your answers, except where your signature is required; that's on page 6.
- Make sure you complete each section of the application.
- Mail your application promptly. We aren't allowed to accept an enrollment application that's dated more than 30 days before we actually receive it.

Section 1	Pick only one plan option
Section 2	Copy the information from your Medicare card onto the picture on the form
Section 3	Choose just one statement that best applies to you
Section 4	Choose how to pay your premium
Sections 5 & 6	Read these carefully and sign in Section 6

Please do not send your payment with this application. Just keep the yellow copy for your records and return the completed form in the postage-paid envelope, or mail it to:

Prescription Blue PDP
P.O. Box 44828
Detroit, MI 48244-0828

What happens next?

- We'll call to make sure that you understand how this plan works and confirm your intent to enroll. If we're not able to reach you by telephone, we will send a letter that explains this.
- Once CMS approves your application, we'll send you a letter confirming your enrollment This usually happens within 30 days.
- We'll bill you based on your plan choice (or automatically deduct your premium if you choose that option).
- You'll receive an information packet about your benefits and the extras you receive with your Blues coverage.

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2014 INDIVIDUAL ENROLLMENT FORM
Prescription Drug Coverage
(Coverage Effective 2014)

Office Use Only:

Please contact Prescription Blue PDP at 1-**888-563-3307** if you have questions, need information in another format or to be referred to our foreign language line**.** Call center hours are 8 a.m. to 9 p.m., Monday through Friday with weekend hours Oct. 1 through Feb. 14. **TTY users should call 711**.

Sec. 1 To Enroll in a Prescription Blue PDP, Please Provide the Following Information:

Please check the plan you want to enroll in:

☐ Option A $62.80 per month ☐ Option B $98.30 per month

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

Birth Date (/ /) (M M / D D / Y Y Y Y)	Sex ☐ Male ☐ Female	Daytime Phone Number ( )	Alternate Phone Number ( )

Permanent Residence Street Address (No P.O. Box)	City	State

Zip Code	County	E-mail Address (Optional)

Mailing Address (Only if different from your permanent residence street address)

Street Address _____

City _____ State _____ Zip Code _____

OPTIONAL INFORMATION

Regular doctor _____

Phone number ( ) _____

Sec. 2 Please Provide Your Medicare Insurance Information.

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue 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 **or** Part B or both to join a Medicare prescription drug plan.

SAMPLE ONLY

Name _____

Medicare Claim Number Sex ☐ M ☐ F

___ ___ ___ - ___ ___ - ___ ___ ___ ___ ___

Is Entitled To: Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Sec. 3 Please Read the Following Statements and Check the Box that Applies to You.

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 confirm that, to the best of your knowledge, you are eligible for an enrollment period. If we later find this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare (effective date ___/___/___).
- ☐ I'm enrolling during the annual enrollment period.
- ☐ 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 have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I live in a long-term care facility (for example, a nursing home or rehabilitation hospital).
- ☐ I recently left PACE® (insert date: ___/___/___).
- ☐ 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 involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date __/___/___).
- ☐ I am leaving/losing employer or union coverage on (insert date: ___/___/___).
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ I recently returned to the U.S. after living permanently outside of the U.S. I returned to the U.S. on (insert date: ___/___/___).
- ☐ In the last 12 months, I left a Medigap policy to join a Medicare Advantage plan* for the first time (*Medicare Advantage plan with prescription drug coverage) (insert date: ___/___/___).
- ☐ In the last 12 months, I joined a Medicare Advantage plan with prescription drug coverage when I turned 65.
- ☐ I get extra help paying for Medicare prescription drug coverage, but do not have Medicaid.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date: ___/___/___).
- ☐ My plan is ending its contract with Medicare or Medicare is ending its contract with my plan (effective date: ___/___/____).
- ☐ I am disenrolling from a Medicare cost plan and had Medicare prescription drug coverage from the Medicare cost plan.
- ☐ I am being disenrolled from a Medicare special needs plan because I no longer have special needs status.
- ☐ I recently lost Medicare Part B but I still have Part A.
- ☐ I am making this enrollment request between January 1 and February 14, and I recently ended my enrollment in a Medicare Advantage plan. I left my Medicare Advantage plan on (insert date:___/___/___).
- ☐ Other _____

*Please contact Prescription Blue PDP at **1-888-563-3307 to see if you are eligible to enroll.** Call center hours are 8 a.m. to 9 p.m., Monday through Friday with weekend hours Oct. 1 through Feb. 14. **TTY users should call 711.**

Sec. 4 Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment fee you may owe) by mail, electronic funds transfer or an automatic withdrawal from your bank account. You can also pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you'll be notified by the Social Security Administration. You'll be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare. **Do NOT** pay the Part D-IRMAA extra amount to Prescription Blue.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment fee. 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.

Sec. 4 Continued — Paying Your Plan Premium

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'll bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you'll get a bill each month. You should know that Social Security LIMITS the automatic deduction amount allowed from your benefit check to $300. This means that, if you select a Prescription Blue plan, – and there's a delay in processing – the transaction will be rejected because the deduction amount would exceed Social Security's $300 limit. You'll then be billed directly for all unpaid premiums. Please choose automatic deductions if you don't want to receive a statement each month.

Please select a premium payment option:

☐ Electronic funds transfer from your bank account each month. Please allow three to four weeks to process your application. Please pay any premium bill you may receive while your application is processing. Future monthly premiums will be automatically withdrawn from your specified account on the fifth day of every month.
Please enclose a **VOIDED** check:

Account holder name: _____

Bank routing number: _____
(first set of numbers located on left side of check)

Bank account number: _____
(second set of numbers located in center of check)

Account type: ☐Checking ☐Savings

☐ Get a bill each month.

☐ Automatic deduction from my monthly Social Security/Railroad Retirement Board benefit check. (The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.) If Social Security/the Railroad Retirement Board doesn't approve your request for automatic deduction, we'll send you a paper bill for your monthly premiums.

Sec. 5 — Please Read and Answer These Important Questions

1. 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 Prescription Blue PDP? ☐ 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: _____

2. 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 of Institution			
City	State	Zip Code	Telephone of Institution

Please contact Prescription Blue PDP at **1-888-563-3307**, if you have questions, need information in another format or to be referred to our foreign language line. Call center hours are 8 a.m. to 9 p.m., Monday through Friday with weekend hours Oct. 1 through Feb. 14. **TTY users should call 711.**

Sec. 6 **Please Read This Important Information**

If you are a member of a Medicare Advantage plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining Prescription Blue PDP, your membership in your Medicare Advantage plan may end. This would affect your doctor, hospital coverage and prescription drug coverage. Read the information that your Medicare Advantage plan sends you. If you have questions, contact your Medicare Advantage plan.

If you currently have health coverage from an employer or union, joining Prescription Blue PDP could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Prescription Blue PDP. 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 information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

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

- Prescription Blue PDP is a Medicare drug plan and has a contract with the federal government. I understand that this prescription drug coverage is in addition to my Medicare coverage. I need to keep my Medicare Part A or Part B coverage. It's my responsibility to let Prescription Blue PDP know about any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare prescription drug plan, my enrollment in Prescription Blue PDP will end that coverage. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the annual enrollment period (October 15 - December 7), unless I qualify for certain special circumstances.

- Prescription Blue PDP serves a specific service area. If I move out of the area that Prescription Blue PDP serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I can't reasonably use Prescription Blue PDP network pharmacies. Once I'm a Prescription Blue PDP member, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Prescription Blue PDP when I get it to know which rules I must follow to get coverage.

- I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or prescription drug coverage that's as good as Medicare's coverage, I may have to pay a late enrollment fee in the future in addition to my premium for Medicare prescription drug coverage.

- I understand that if I get help from a sales agent, broker or other individual employed by or contracted with Prescription Blue PDP, he/she may be paid if I enroll in Prescription Blue PDP. Counseling services may be available in my state to offer advice about Medicare supplement insurance or other Medicare Advantage or prescription drug plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Sec. 6 Continued **Please Read and Sign Below**

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that Prescription Blue PDP will release my information to Medicare and other plans as needed for treatment, payment and health care operations. I also acknowledge that Prescription Blue PDP will release my information, including my prescription drug data, to Medicare, who may release it for research or 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 provide false information on this form, I will be disenrolled from this plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under state law 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 Prescription Blue PDP or by Medicare.

Signature	Today's Date

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

Name	Phone Number ( )

Address	City	State	Zip Code

Relationship to Enrollee

AGENT/OFFICE USE ONLY (Applicants do not complete this section)

Note to producing agents: *2014 paper enrollment forms must be keyed into www.bcbsm.com/acessmedicare or submitted to the managing or general agent within 24 hours of accepting the paper enrollment form.*

Date producing agent accepted paper enrollment from Medicare eligible: ☐☐/☐☐/☐☐☐☐

Date managing/general agent or association received paper enrollment form from producing agent: ☐☐/☐☐/☐☐☐☐

Name of managing/general agent or association: _____

Name of producing agent *(print first/last names):* _____ _____
First Name Last Name

Signature of producing agent: _____

Email of producing agent: _____

2-digit managing/general agent or association code: ☐☐ 5-digit producing agent code: ☐☐☐☐☐

I helped the applicant by partially or completely filling out the paper enrollment form on behalf of the applicant: ☐ Yes ☐ No

Name of person entering enrollment information online (print first/last names): _____ _____
First Name Last Name

BCBSM Source Code: ☐☐☐☐☐☐☐☐☐ BCBSM Badge # : **E** ☐☐☐☐☐☐