MEDICARE ADVANTAGE

2012

Enrollment Application

Senior Blue HMO
Forever Blue Medicare PPO
Optional Supplemental Dental

If you have any questions, we're here to help!

www.bcbswny.com/medicare

1-888-587-BLUE (2583)
TTY users should call 1-877-286-5710

October 15-February 14	8 a.m. to 8 p.m., 7 days a week
February 15-October 14	8 a.m. to 8 p.m., Monday-Friday

During non-business hours, your call will be answered by our automated phone system. A representative will return your call on the next business day.

healthy changes everything.®

BlueCross BlueShield of Western New York

A division of HealthNow New York Inc., an independent licensee of the BlueCross BlueShield Association.

A Medicare Advantage organization with a Medicare contract.

Please contact BlueCross BlueShield of Western New York if you need information in another language or format.

To Enroll in Senior Blue HMO/Forever Blue Medicare PPO, Please Provide the Following Information:

Please check which plan you want to enroll in:

- ☐ **Senior Blue HMO 601** $0 monthly premium
- ☐ **Senior Blue HMO 651** $0 monthly premium
- ☐ **Senior Blue HMO 653** $95.00 monthly premium
- ☐ **Forever Blue Medicare PPO 701** $40.00 monthly premium
- ☐ **Forever Blue Medicare PPO 751** $111.00 monthly premium
- ☐ **Optional Supplemental Dental** $10.00 additional monthly premium with any plan listed here

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 ( )

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

City **State** **ZIP Code**

Mailing Address (Only if different from your Permanent Residence Address):

Street Address

City **State** **ZIP Code**

Emergency Contact

Phone Number **Relationship to You**

E-mail Address

Y0086_ENR264 CMS Approved 08152011

Please Provide Your Medicare Insurance Information

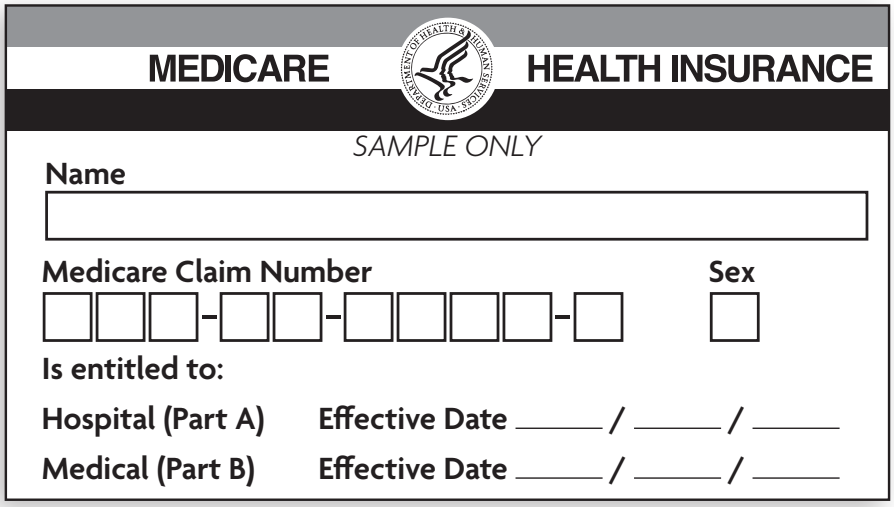
Please take out your Medicare card to complete this section.

- 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 and Part B to join a Medicare Advantage plan.


MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name

Medicare Claim Number **Sex**

☐☐☐-☐☐-☐☐☐☐-☐ ☐

Is entitled to:

Hospital (Part A) **Effective Date** _____ / _____ / _____

Medical (Part B) **Effective Date** _____ / _____ / _____

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 Automatic Payment Option each month, quarterly, biannually, or annually. 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 BlueCross BlueShield 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 co-insurance. 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 receive a bill each month.

Please select a premium payment option:

☐ Get a bill: ☐ MONTHLY ☐ QUARTERLY ☐ BIANNUALLY
☐ ANNUALLY (Annual billing is only offered in January.)

☐ Automatic Payment Option (APO) from your bank account each month. [1]
Please include 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. [1]
(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.)

[1] If you enrolled in the EPIC fee plan, we cannot offer Social Security Deduction or APO.

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 Senior Blue HMO or Forever Blue Medicare PPO?

☐ **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**

Important questions continued

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 that we send you information in a language other than English or another format:

☐ Language (call for availability) ☐ Alternate Formats (call for availability)

Please contact BlueCross BlueShield of Western New York at 1-888-587-BLUE (2583) if you need information in another format or language than what is listed above. TTY users should call 1-877-286-5710. Our office hours are:

October 15-February 14	8 a.m. to 8 p.m., 7 days a week
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Please Read This Important Information

If you currently have health coverage from an employer or union, joining Senior Blue HMO or Forever Blue Medicare PPO could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Senior Blue HMO or Forever Blue Medicare PPO. 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 the next page

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

BlueCross BlueShield of Western New York 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 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 (Example: October 15 – December 7 of every year), or under certain special circumstances.

BlueCross BlueShield of Western New York serves a specific service area. If I move out of the area that BlueCross BlueShield of Western New York 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 BlueCross BlueShield of Western New York, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from BlueCross BlueShield of Western New York 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 Senior Blue HMO coverage begins, I must get all of my health care from BlueCross BlueShield of Western New York, except for emergency or urgently needed services or out-of-area dialysis services. I understand that beginning on the date Forever Blue Medicare PPO coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Forever Blue Medicare PPO provides refunds for all covered benefits, even if I get services out of network. Services authorized by BlueCross BlueShield of Western New York and other services contained in my Senior Blue HMO or Forever Blue Medicare PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR BLUECROSS BLUESHIELD OF WESTERN NEW YORK 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 BlueCross BlueShield of Western New York, he/she may be paid based on my enrollment in Senior Blue HMO or Forever Blue Medicare PPO.

Release of Information:

By joining this Medicare health plan, I acknowledge that BlueCross BlueShield of Western New York will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that BlueCross BlueShield of Western New York 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

Address

Phone Number

( )

Relationship to Enrollee

Office Use Only

Name of staff member/agent/broker (if assisted in enrollment):_____

Plan ID # _____

Effective Date of Coverage: _____

ICEP/IEP:_____ AEP:_____SEP (type): _____ Not Eligible _____

Broker/Agent Name :_____ ID #_____

Agency_____